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# The Illinois Medical Journal

The Official Journal of

## The Illinois State Medical Society




**Index to Volume 109**

**January—June, 1956**

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Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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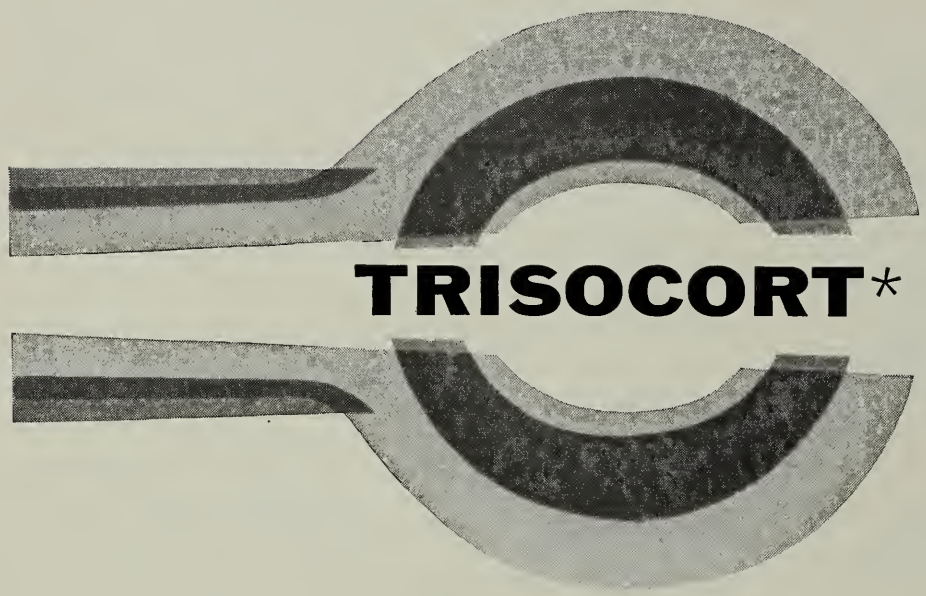
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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.

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# The Month in Washington



Washington, D. C. — The second session of the 84 Congress is under way, and in medical legislation — as in all other fields — this promises to be much livelier than last year's deliberations.

For one thing, neither the Republican administration nor the Democratic party, which is in control on Capitol Hill, got anywhere near as much as it wanted last year in medical legislation.

For another thing, and something that shouldn't be lost sight of at any time, both parties this year will be legislating with one eye cocked toward next November, when the voters make a choice between the two parties. Try as they might to pass laws for the good of all the people, neither party can afford to ignore the political realities of the situation: each will want to take credit for any legislation with popular appeal or where that is impossible, at least to see that the other party doesn't get the credit.

In front of this political mosaic, these are some of the medically-important issues that will be fought out in Senate and House:

1. Federal guarantee of mortgages on health facilities. This has been on the Congressional calendar for two years; it was pushed hard in 1954, and was given some consideration in 1955. It would mean that the federal government would underwrite mortgages for hospitals, clinics and nursing homes, under certain conditions, thereby allowing some sponsors to obtain loans they couldn't otherwise get, or to obtain them on longer terms and with lower interest.

2. Federal grants for research facilities. Under this plan — approved last session by the Senate — the U.S. would make outright grants to laboratories, medical schools and clinics for building facilities for research in specific diseases, such as cancer and heart disease.

3. Federal aid to medical education. This perennial project probably is closer to Congressional enactment now than ever before. The most popular bill is one restricting the federal role to grants for building and equipment, with a financial incentive held out to those schools willing to increase their enrollment. This bill may be tied in with some other grants bill, such as the one for research.

4. Salk vaccine. Legislation authorizing federal appropriations for the purchase of Salk poliomyelitis vaccine ($30 million for the current year) expires February 15, virtually insuring Congressional action of some sort before that date. One issue is whether the federal government should continue the grants; more controversial is the question of whether the U.S. should move in to control the allocation and distribution of the vaccine. Allocation and distribution now are handled under a voluntary program supervised by the U.S. Public Health Service.

5. Increases in federal appropriations for medical research. Over the last few years — since the National Institutes of Health came of age — Congress repeatedly has increased research grants over the amounts the Budget Bureau allowed Public Health Service to request. Indications are that this year the Budget Bureau may have to give way and allow important increases to be requested of Congress. Congress probably would want to add on its own special

**WASHINGTON (Continued)**

additions anyway, resulting in more money than ever before available for work on cancer, heart disease, mental illness, arthritis, blindness and many other conditions.

6. OASI-covered persons could receive payments beginning at age 50 if determined to be disabled. Under present law retirement payments for all are available at age 65. The bill containing this provision (H.R.7225) passed the House last session by an overwhelming margin. It is now before the Senate Finance Committee, where the next phase of the legislative contest will be fought out in 1956.

The lop-sided House vote on disability payments may be discounted in part because of the parliamentary maneuvering by sponsors of the legislation. House members had only 40 minutes to debate this bill, and no opportunity to amend it. It was a case of accepting the whole bill — which contains a number of other social security liberalizations not of medical significance — or being politically damned as opposed to social security per se.

The American Medical Association maintains that the present expanding rehabilitation programs would be undermined by cash payments for disability, that the financial and other long-range aspects of the disability payments plan have not been thoroughly studied, and that the machinery for disability payments would inevitably project the federal government deeply into the medical care picture.

## The origin of toilet paper

Toilet paper was unbleached, pearl colored, pure manila hemp paper made in 1857 by Joseph G. Gayetty, of New York City, whose name was watermarked on each sheet. It sold at 500 sheets for 50 cents and was known as Gayetty's Medicated Paper, a perfectly pure article for the toilet and for the prevention of piles. *Joseph N. Kane, Famous First Facts (Wilson, N.Y. 1950).*


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**Official Journal of The Illinois State Medical Society**

JANUARY 1956
VOL. 109 NO. 1

# The Gastric Ulcer Problem

**E. Clinton Texter, Jr., M.D., Chicago**

THE management of a patient with a gastric ulcer is one of the most controversial subjects in clinical medicine. Most physicians feel that gastric ulcer is primarily a medical problem, but surgery is recommended if satisfactory healing does not take place, if the ulcer recurs or if there is suspicion of cancer. Many surgeons advocate immediate resection of all gastric ulcers.

Why does the gastric ulcer patient present so many problems to the clinician? The diagnosis of gastric ulcer may be difficult because of the variable symptomatology. The symptoms of gastric ulcer are much less characteristic than those of duodenal ulcer, and frequently, it is the roentgenologist who first recognizes the gastric ulcer.

The more important aspect of the problem concerns the differential diagnosis between benign gastric ulcer and ulcerating carcinoma of the stomach. The reported incidence of gastric carcinoma presenting as an apparently benign gastric ulcer ranges from 1 to more than 20 per cent.[1] For the most part the higher figures emanate from surgical centers and are used as an argument for immediate gastric resection for all gastric ulcers. The more recent studies indicate that the error in diagnosis is low. When patients are carefully studied with a specific purpose of differentiating gastric carcinoma from benign gastric ulcer, the diagnostic error may be as low as 1 per cent.[2]

## DIAGNOSIS OF GASTRIC ULCER

The diagnosis of gastric ulcer is based upon careful evaluation of the clinical features presented by the patient. These should be supplemented by careful roentgen study of the stomach, gastroscopic examination, and study of the exfoliated mucosal cells from the stomach when available.

The history may be variable. Gastric ulcers may be entirely asymptomatic. Nausea and vomiting, suggestive of gastric retention, may be the initial complaint. These symptoms are most common with ulcers located in the pyloric channel.[3] Hemorrhage is the first manifestation of ulceration in approximately 20 per cent of patients. However, the most common symptom is gnawing or burning epigastric distress occurring after meals which is usually relieved by food or alkali.

In comparison to the history, the physical examination is of relatively little value in the diagnosis of gastric ulcer. Tenderness may be

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*Presented in part at the Post Graduate Course in Medicine of the Chicago Medical Society, Chicago, November 1954 and at the Post Graduate Conference of the Illinois State Medical Society, Jacksonville, March 10, 1955.*

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present over a gastric ulcer located in a palpable area, particularly if penetration has taken place. Usually the physical examination is negative in the patient with a gastric ulcer. Examination is of value in excluding other diseases with similar symptoms.

Gastric analysis and the examination of the stool for occult blood are of limited value. The persistent failure to obtain free acid after histamine stimulation strongly suggest that the gastric ulcer is malignant. Occult blood may be present in the stool of patients with gastric ulcers, but the persistence of occult blood in the stool over a long period is more indicative of an ulcerating malignancy.

Study of the exfoliated cells of the gastric mucosa is important in distiguishing gastric ulcer from gastric cancer. The cells are obtained with an abrasive balloon or brush or after instillation of a mucolytic agent such as papaine or chymotrypsin. A positive diagnosis of gastric cancer based solely on the study of the exfoliative cells can be made in approximately 85 per cent of patients having gastric cancer. There are limitations to the use of the exfoliative cytology method. Adequate study of the cytologic material is time consuming. Furthermore cytologic studies are not generally available because of insufficient personnel trained in this technique.

Gastroscopic examination is indicated whenever it is thought that a gastric ulcer can be visualized and there are no contra-indications to the procedure. The benign gastric ulcer can be seen as a punched out ulcer with smooth edges and a clean looking base. In contrast, ulcerating malignancies usually have nodular or infiltrated edges. Biopsy of the lesion by the gastroscopist has added to the usefulness of this diagnostic procedure.

The most important adjunctive diagnostic aid is careful roentgen study of the stomach. The principal roentgen sign of gastric ulcer is a barium-filled crater. Indirect signs of ulceration such as spasm, changes in mucosal relief pattern, or evidences of gastric retention may be observed.

Approximately three-quarters of all gastric ulcers are located in the region of the lesser curvature, most of these being close to the incisura angularis. The pre-pyloric area is a site for 20 per cent of gastric ulcers. Approximately 12 per cent of gastric ulcers are located in the pyloric channel. Between 5 and 10 per cent of gastric ulcers are located in the cardia and only 3 per cent of all gastric ulcers are found on the body or the greater curvature of the stomach. When benign ulcers occur in this area, they present diagnostic difficulties.

Case 1. (PMH 54-5831) a 65-year old man was found on follow-up x-ray study to have a recurrent ulcer on the greater curvature of the stomach. He had a history of gastric ulcer diagnosed 4 years previously. Gastroscopic examination revealed antral gastritis. Occult blood was absent in the stool. Because of inability to rule out carcinoma, laparotomy was recommended. A large benign ulcer was found located on the greater curvature. He made an uneventful recovery following gastric resection. (Figure 1).

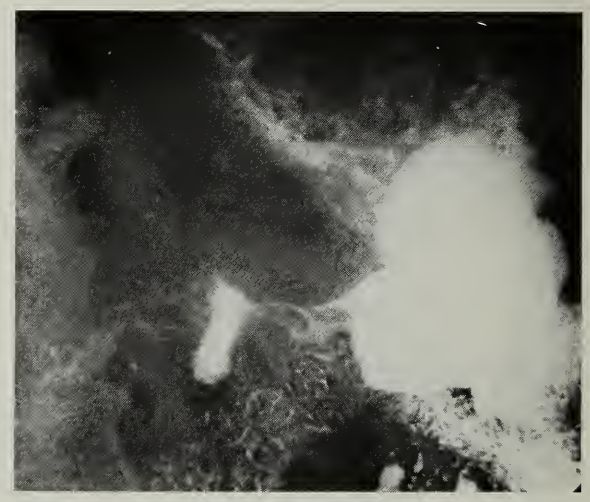


**Figure 1. X-ray showing ulcer of greater curvature with filling defect involving the antrum. (Reprinted from Barborka, C. J. and Texter, E. C., Jr. PEPTIC ULCER — DIAGNOSIS AND TREATMENT, Boston, Little, Brown. 1955)**

It is important to recognize the limitations of the roentgenologist when presented with a gastric ulcer. The ulcer may not be observed by the examiner if it is located either on the anterior or posterior wall of the stomach or is in an area inaccessible to palpation. Size of the ulcer formerly was thought to be a useful criterium in determining whether the ulcer was benign or malignant. This is not the case. None the less, large ulcers present difficult problems and are frequently confused with carcinoma. When of benign origin they are usually the result of penetration and walled-off perforation and seldom heal on a medical program.

Case 2. (PMH 55-262) a 39-year old woman had pain, vomiting and weight loss. A diagnosis of inoperable gastric carcinoma had been made else-

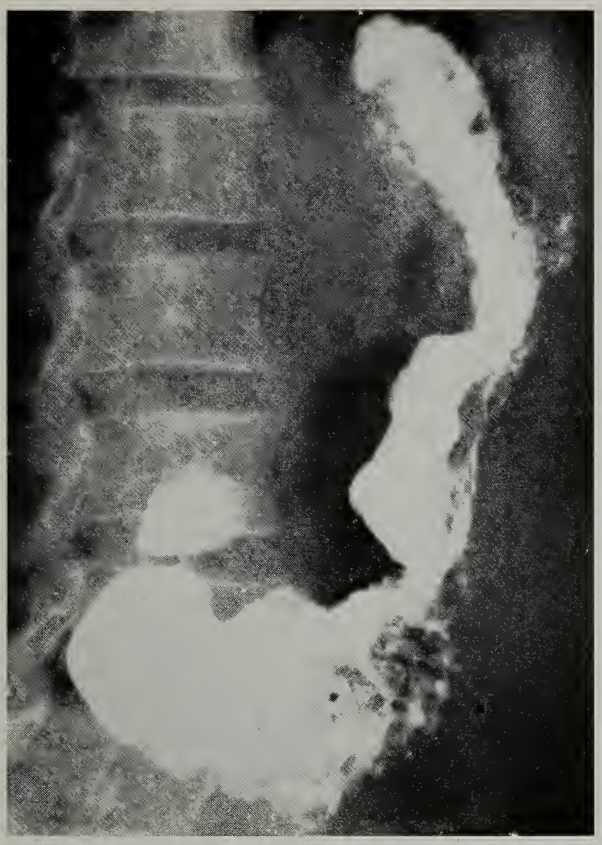


**Figure 2. X-ray showing a 4 by 8 cm. crater projecting from the lesser curvature side of the stomach.**

where. Roentgen study of the stomach revealed a 4 by 8 cm crater projecting from the lesser curvature with distortion of the rugal folds and gastric retention. (Figure 2). Blood was present in the gastric aspirate. After intensive medical treatment, including gastric suction, progress films showed the ulcer increased in size, and resection was recommended. Preoperatively it was felt that she had a large benign ulcer which had penetrated through the body of the pancreas. At surgery, the pancreas was found to be tremendously enlarged in its midportion and was attached to the posterior gastric wall over an area of 12 by 5 cm. A massive benign penetrating gastric ulcer was plastered to the pancreas. (Figure 3). There was also a second ulcer involving the anterior surface of the lesser curvature. She made an uneventful recovery after sleeve resection of the stomach accompanied by pyloroplasty.

## TREATMENT OF GASTRIC ULCER

Both medical and surgical treatment have indications and limitations. There are two important factors which influence what type of treatment should be recommended; one, the ability of the clinician to distinguish preoperatively between benign and malignant ulcer, and two, the long-term results of treatment.

In favor of immediate surgical resection of all gastric ulcers are the following: (1) There has been little improvement in the survival rate of patients with carcinoma of the stomach primarily because operations are not carried out before metastasis have developed. (2) Early resection of all patients with gastric ulcer may salvage an apprcciable number of cases early even though These patients so treated cannot be proved to have a gastric malignancy. (3) The distinction between benign and malignant gastric lesion cannot be made with sufficient accuracy to permit prolonged conservative treatment. (4) The results of gastric resection for a gastric ulcer are good, and (5) to delay surgery until the trial of medical management has been carried out may be hazardous as far as the optimum time for resection is concerned.[4] Persistent achlorhydria following histamine, a positive Papanicolaou test or roentgen evidence of malignancy are indications for surgery.

In favor of medical management and against immediate surgical intervention are the following: (1) By careful study one can distinguish between benign ulcer and ulcerating cancer with a high degree of accuracy; (2) inasmuch as the 5-year cure for carcinoma of the stomach is low, a delay of several weeks would not appreciably alter the ultimate results of surgery, and (3) operation for gastric ulcer is not without risk.

The diagnostic error of mistaking an ulcerating carcinoma for a benign ulcer appears to have been overestimated in the past. The error should



**Figure 3. Post-operative specimen of the stomach showing the large benign ulcer which had penetrated to involve the pancreas.**

be at least as low as the usual surgical mortality; namely, 3 to 5 per cent and it may be as low as 1 per cent.

In reviewing approximately one hundred patients with gastric ulcer seen in the past 30 months, only two were demonstrated to have a gastric neoplasm which was not suspected or diagnosed preoperatively. In each of the two instances, the patients were referred for surgery promptly.



**Figure 4. X-ray showing a large irregular crater projecting from the posterior wall of the lesser curvature of the stomach.**

Case 3. (PMH 55-1336) was a 65-year old man with a 6 weeks history of epigastric pain and vomiting. The pain was relieved by food and alkali. Routine x-rays of the stomach were negative but on deep pressure a large irregular crater could be seen projecting off the posterior wall of the lesser curvature. (Figure 4). Free acid was present and there was no occult blood in the stool. The ulcer could not be visualized gastroscopically because of its location. He improved markedly during a two week trial of medical management but x-rays showed no significant evidence of healing and laparotomy was recommended. A large gastric ulcer was found which was adherent to the pancreas. The lesion appeared benign on gross inspection but localized adenocarcinoma, grade 2, was found on microscopic section. He is clinically well 5 months after gastric resection.

Case 4. (PMH 53-4859) was a 66-year old man admitted with ulcer pain and massive gastric hemorrhage. Emergency x-ray studies as an outpatient revealed a duodenal deformity with a suspicion of crater. He continued to bleed and after three weeks of conservative treatment laparotomy was performed. A gastric ulcer 3.5 by 1.5 cm was resected which appeared grossly to be benign. Microscopic studies showed undifferentiated adenocarcinoma. He is clinically well 20 months following resection.

Treatment for the patient with an uncomplicated gastric ulcer consists of dietary management, supplemented by non-absorbable antacids and sedation. The antichlorinergic agents are useful as adjunct therapy. The use of coffee, alcohol, tobacco, and other agents which stimulate secretion should be curtailed. Careful roentgen study should be carried out at intervals of 10 days to two weeks. These should be supplemented by gastroscopic examination and study of the exfoliated cytology if available. The patient should be hospitalized until complete healing can be demonstrated or until a decision can be made regarding surgical treatment. This decision can usually be made within two or three weeks. Even though healing may not be complete this time, there will be sufficient evidence of healing so that medical treatment can be justifiably continued. Surgery is recommended if the ulcer shows no evidence of healing, or if it is so large that healing will not take place on a medical program. Recurrent gastric ulcer is also a strong indication for surgical therapy.

If complications are present, the treatment program differs. Most instances of gastrointestinal bleeding can be handled with the medical program supplemented by transfusions. If the bleeding is continued or recurrent, surgery may be required. Surgery may be also necessary for the other complications including obstruction, perforation or the development of walled-off perforation.[5] The other major indications for surgery is the suspicion of gastric cancer. The operation of choice is gastric resection with removal of the ulcer. Modifications of either the Billroth I, Billroth II or tubular resection may be employed either with or without vagotomy.

## RESULTS OF TREATMENT

The results of treatment reported in the literature vary considerably. Smith, et al[6] reporting on 912 patients with gastric ulcer indicate that the results of treatment in both the medically and surgically treated patients are identical. Good results were reported in 78.7 per cent of 380 patients available for follow-up who were

treated by gastric resection. Good results were reported by 75.1 per cent of 397 patients who were treated medically. The major indication for surgical treatment was suspicion of cancer. The overall incidence of cancer in this series of 1,000 patients with an apparently benign ulcer was 8.8 per cent, but the incidence was 16 per cent in patients with recurrent gastric ulcers.

Banks and Zetzel[7] who followed the clinical course and late results of medical management of gastric ulcer in 48 patients for periods up to 15 years, are less enthusiastic. Only 11 patients of 38 available for follow-up were symptom free during the entire period. They report that recurrences may be expected to occur in 50 to 90 per cent of patients with gastric ulcer during a 5 year follow up. Gastric resection was recommended to protect the patient both from recurrences and also from the possible jeopardy of an unsuspected gastric cancer.

Swynnerton and Tanner[8] followed 387 men and 111 women with chronic gastric ulcer during the period of 1940 to 1946. Approximately one-half of the patients were treated medically while the remainder were treated surgically. The criteria for inclusion in the study was the presence of an active gastric ulcer which in the medical series was seen gastroscopically. The follow-up period varied from 5 to 12 years. The indications for surgery were primarily pyloric obstruction or failure of medical management. The overall surgical mortality was 6.3 per cent. Satisfactory results were obtained in 80 per cent of the surgically treated patients whereas symptoms of gastric ulcer recurred in three-quarters of the medically treated patients. They concluded that medical treatment might heal the ulcer but would keep it healed in less than one-quarter of patients.

It is difficult for the clinician to know what results to expect from treatment in the individual patient in the face of such conflicting reports. If the results of medical treatment are good with little likelihood of recurrence in the future, a strong case can be made for conservative medical management. If the results of medical treatment are not satisfactory and recurrences can be expected in the majority of patients, early operation could then be justifiably recommended to the majority of patients with gastric ulcer.

Certain tentative recommendations regarding treatment can be made. The diagnosis of gastric ulcer can be made with a high degree of accuracy if the patients are studied carefully. Medical treatment of gastric ulcer is justified in many cases. If the results of medical treatment are not saisfactory, or if the diagnosis is not clearly established, surgery should be recommended. The results of surgery are satisfactory in approximately 80 per cent of cases. The usual surgical mortality of 3 to 5 per cent is still far from negligible. The development of a recurrent ulcer is a strong indication for surgery, primarily because a recurrence indicates the ulcer is intractable to medical management.

The physican treating the patient with a gastric ulcer has a great obligation to follow the subsequent course of the patient. The patient should not be discharged from the hospital without roentgen evidence that the ulcer has healed. Periodic follow-up studies are necessary to be certain that recurrence does not develop.

Satisfactory therapeutic results can be obtained in the majority of patients with gastric ulcer. The early results of medical treatments are good in the majority of patients with only about 15 per cent of patients requiring early surgery. It tory result from medical management during a would appear that only half of patients with uncomplicated gastric ulcers achieve a satisfaclong follow-up period. The remaining half of the patients will ultimately require surgery for the treatment of complications, the development of intractability, or for patients in whom the diagnosis of ulcerating gastric malignancy cannot be definitely excluded.

303 East Chicago Avenue

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# Cortisone Treatment of Subacute Thyroiditis

**Robert M. Hoyne, M.D., Urbana**

SUBACUTE thyroiditis was first studied in detail in 1904 by the Swiss surgeon, De-Quervain, and has sometimes been called De-Quervain's disease.[1] For years this condition was confused with other nonsuppurative thyroid disturbances such as Hashimoto's disease (struma lymphomatosa) and Riedel's struma (ligneous or woody thyroiditis). However, subacute thyroiditis is now considered clinically and pathologically distinct from these other conditions.[2]

During recent years the therapy of this disease has included the use of cortisone and ACTH. Our experiences in the treatment of 10 cases of subacute thyroiditis with cortisone have prompted this report.

## CLINICAL ASPECTS

The onset of this disease usually is sudden and in about one-fourth of the cases follows an acute upper repiratory infection. In rare cases it has been reported to follow measles, malaria, scarlet fever and other diseases.[3] Most cases occur in the fourth and fifth decades, although three patients in the present series were older than 50 years. Women are more often affected and outnumbered men 7:3 in this report.

Practically all patients complain of soreness in the throat or neck which may be of extreme severity. The pain commonly is referred to the ears, teeth, or face and sometimes is aggravated by swallowing. Cough may be experienced as a result of tracheal irritation and hoarseness has been occasionally noted. Fever with or without chills is a common symptom and occurred in five cases of the present series. The pulse rate may be elevated out of proportion to the fever. Generalized symptoms such as weakness, weight loss, sweats, nervousness, and emotional instability may be present and at times raise the clinical suspicion of thyrotoxicosis. Usually, however, the systemic picture is one of toxemia rather than hypermetabolism and eye signs have not been reported in this condition.

Some degree of tenderness of the thyroid gland invariably is present and may be of exquisite intensity. The gland is usually enlarged and firm but may be stony-hard and raise the suspicion of malignancy. The entire thyroid may be involved or only one lobe although the process in some cases begins in one area and spreads throughout the gland (so-called "creeping or migratory thyroiditis").[3] The regional lymph nodes are characteristically not enlarged in subacute thyroiditis.

## ETIOLOGY

The cause of this condition is unknown. No bacterial organisms have been demonstrated in cultures of removed tissues and the possibility of a viral etiology has not been excluded.

## DIAGNOSIS

The diagnosis of subacute thyroiditis may be suspected from the clinical course. However, the distinction between soreness in the throat and soreness in the neck is not always clear-cut so that some cases may be treated for only an upper respiratory infection until the tender, enlarged thyroid gland is noted.

Laboratory findings are not remarkable except for the sedimentation rate which is characteristically elevated and often out of proportion to the febrile reaction. In the present series markedly elevated sedimentation rates were found in seven of eight cases tested. The basal metabolism rate does not yield diagnostic information in view of the fever and toxemia. Protein-bound iodine concentrations in the plasma may give normal or elevated readings.

Sometimes the clinical picture of nervousness, tachycardia, and weight loss may lead to the erroneous suspicion of hyperthyroidism. In these cases the correct diagnosis often can be derived from the radioactive iodine uptake study which is markedly reduced in most cases of subacute thyroiditis and elevated in thyrotoxicosis.[3]

In questionable cases needle biopsy of the thyroid gland may reveal the true pathologic

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*Presented before the Section on Medicine, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1955.*

picture. Crile[4] reported needle biopsies in over 200 cases without bleeding or other complications.

## PATHOLOGY

On microscopic examination abundant cellular infiltration may be seen consisting of polymorphonuclear neutrophiles, lymphocytes, plasma cells, giant cells, and focal accumulation of histiocytes. Other areas may show considerable fibrosis especially in the connective tissue partitions. The follicles often appear degenerated and the colloid may be spilled into the interacinar tissues. Here the colloid may serve as a foreign body irritant in causing this granulomatous reaction, for in focal areas wandering cells may be seen phagocytizing this colloid material. Gross[5] has recently suggested that anisotropic crystalline material (calcium oxalate monohydrate) may be the irritating factor in this reaction. Because of this pathologic picture subacute nonsuppurative thyroiditis is also known as pseudotuberculous or giant cell thyroiditis. (Figure 1, 2, 3)

This inflammatory reaction usually involves the entire gland but in some cases may be localized and simulate or complicate a thyroid adenoma. Subacute thyroiditis in an adenomatous gland occurred in only three of 38 cases reported by Crile and Rumsey[3] and in only one case of the present series.

## TREATMENT

Subacute thyroiditis usually is a self-limited disease lasting a few weeks with spontaneous recovery and no permanent thyroid damage. Schlicke[6] mentioned one patient with a pre-existing adenomatous goiter who was subjected to thyroidectomy five months after the subacute thyroiditis had apparently subsided. Pathologic examination revealed that residual fibrosis and leukocytic infiltration were still present.

Occasionally subacute thyroiditis runs a prolonged course with disability for many months. These chronic cases usually have little if any fever, less pain and thyroid tenderness, fewer systemic symptoms, and lower sedimentation rates.

Most often the disease can be handled conservatively with thyroidectomy indicated only for protracted or complicated cases. In mild attacks symptomatic treatment with hot or cold packs, analgesics, sedatives, and rest is all that is necessary. In more severe cases, iodides, thyroid ex-

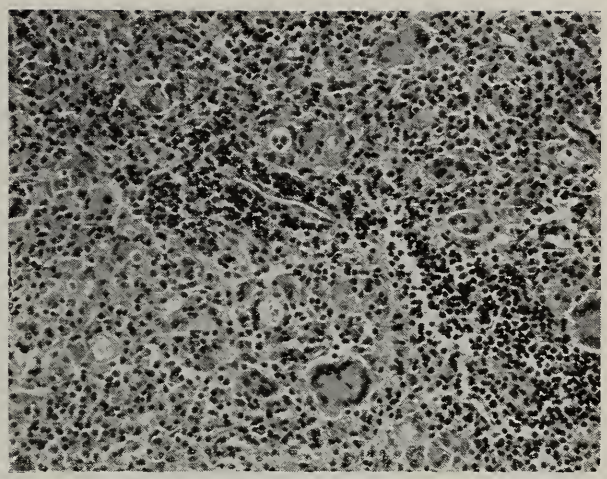


**Figure 1. Thyroid tissue removed surgically from a case of subacute thyroiditis not treated with cortisone. Note the increased cellularity, granulomatous reaction and giant cells. (X 150)**

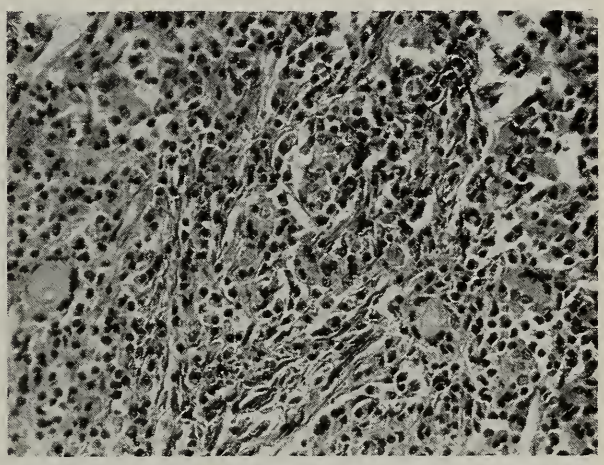


**Figure 2. Same case as Figure 1. Note the increased fibrosis and cellular infiltration. (X 210)**

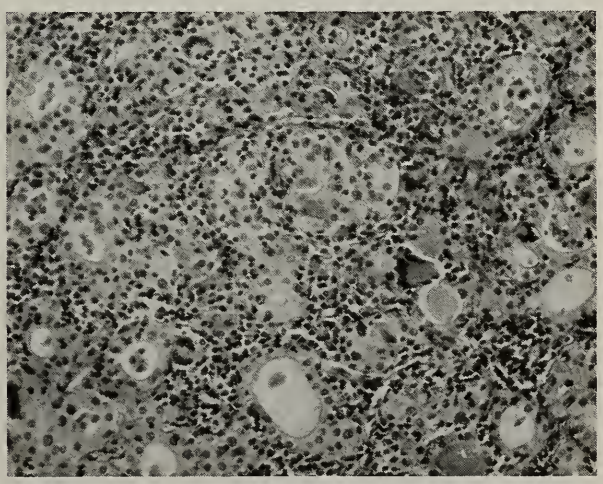


**Figure 3. Same case as Figure 1. Note the colloid spilled from degenerating thyroid follicles resulting in a foreign-body granulomatous process with giant cells. (X 210)**

tract, sulfonamides, penicillin, and other antibiotics have been employed without specific benefits. Thiouracil and other antithyroid drugs have been used with inconsistent results.[7,8] Radioactive iodine has not proved effective, probably because of the low uptake in this disease.

Until recently the treatment of choice was X-ray therapy to which the disease often responded with subsidence of pain and temperature in a few days and complete remission in a few weeks. Osmond and Portmann[9] of the Cleveland Clinic reported roentgen therapy in 55 cases with favorable results in 40 patients. An additional six cases benefited from a second course of X-ray therapy. Usually 600-1000r resulted in satisfactory resolution within a few weeks. However, Allen and Reeves[10] noted a 27 percent recurrence rate in their cases treated with X-ray therapy.

The use of cortisone in subacute thyroiditis was apparently first reported by Kinsell in 1951.[11] Soon thereafter Crile and Schneider[12] reported three cases benefiting from cortisone and one from ACTH therapy. Since then numerous reports have appeared in the literature verifying the apparent specificity of steroid therapy for this condition without any reports of unfavorable results.[13, 14, 15, 16, 17, 18, 19]

Ten cases of subacute thyroiditis have been treated with cortisone at Carle Hospital Clinic and form the basis for this report. None of our cases to date have been treated with ACTH, hydrocortisone, or metacortandrocin, but similar suppressive benefits could be anticipated from any of these medications. All 10 patients responded promptly to cortisone therapy but at least three experienced recrudescence of symptoms on premature cessation or diminution of cortisone dosage. One of these cases will be described in greater detail.

## CASE REPORT

On June 22, 1954, a 43 year old housewife was seen at Carle Hospital Clinic complaining that an upper respiratory infection five weeks before admission had been followed by persistent soreness of the neck. A tender nodule about 1.5 x 2 x 1 cm. in size was palpable in the left lobe of the thyroid gland but the physical examination was otherwise not remarkable. No fever was detected but the sedimentation rate was elevated to 85 mm. in 45 minutes using the Westergren method. A diagnosis of subacute nonsuppurative thyroiditis was made and oral cortisone was prescribed in dosage of 25 mg. three times daily with potassium supplement.

Nine days later the thyroid enlargement and tenderness had markedly diminished and the sedimentation rate had fallen considerably. Cortisone dosage was reduced to 25 mg. two times daily. Two weeks later thyroid tenderness had recurred and the sedimentation rate had risen. Cortisone administration was increased to 75 mg. daily with symptomatic benefit and lowering of the sedimentation rate.

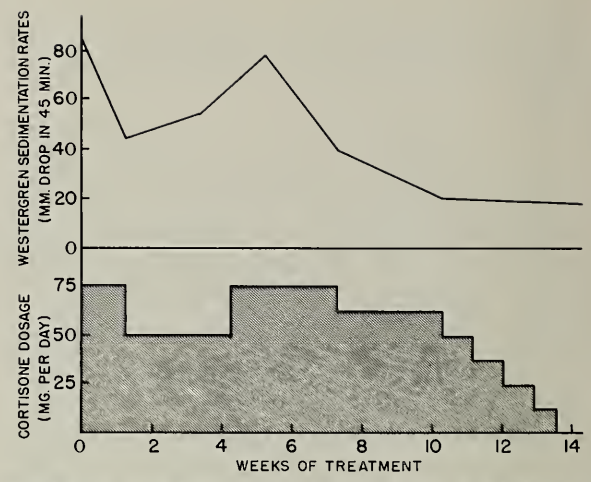



**Figure 4. Relationship of cortisone dosage and sedimentation rate in a case of subacute thyroiditis.**

Thereafter cortisone dosage was gradually reduced during the next five weeks making a total period of about three months of cortisone administration. This resulted eventually in complete disappearance of all thyroid swelling and soreness and return to normal of the sedimentation rate. (Figure 4). When last seen for this illness on September 30, 1954, the basal metabolism rate was -3 and the patient was asymptomatic with no clinical evidence of myxedema.

## COMMENT

The mode of action of cortisone in subacute thyroiditis is unknown. It is unlikely that it acts by reducing iodine uptake for the radioactive iodine uptake is characteristically low in these cases. It is more probable that cortisone produces clinical benefits through nonspecific suppressive effect on the inflammatory tissue reactions.

All cases of subacute thyroiditis in the present series responded dramatically to cortisone therapy with prompt subsidence of symptoms usually within a few days, gradual resolution of thyroid enlargement and tenderness, return of the sedimentation rate to normal, and eventual recovery. However, three of the 10 patients relapsed on premature withdrawal of cortisone and required supplemental and prolonged administration. Similar experiences have been noted by others.[4, 14, 15, 17, 18, 19] These reports suggest that cortisone is effective in subacute thyroiditis only for

suppression of symptoms and that its administration may not actually shorten the course of this disease.

The optimal dosage and the duration of cortisone treatment have not been determined. Clark[13] used a single daily dose of 25 mg. for 12 to 14 days and noted no recurrence in his three cases. On the other hand Gelfand[19] and co-workers employed large suppressive doses for two weeks and still noted relapses in two of four cases. In the present series cortisone administration usually began with 75 mg. daily in divided doses for one to two weeks and was then reduced as rapidly as the patient's symptoms would permit. However in severer cases with higher fever, more extensive thyroid involvement and greater prostration, initial cortisone dosage might need to be larger than was employed here. Physiologic side effects can usually be avoided by frequent clinical observation and by tapering off cortisone dosage whenever possible. Sedimentation rates were checked at frequent intervals and served as indices of inflammatory activity. As suggested by Lasser[14], cortisone therapy usually was not stopped until return of the sedimentation rate to normal. Seven of the 10 patients in the present series received cortisone for more than 30 days and four cases for over 60 days.

The impairment of adrenal cortical function by prolonged cortisone administration has been recognized and serious complications have been reported.[20] The advisability of using cortisone for long periods of time in treating a self-limited disease might be questioned. However, subacute thyroiditis often is an extremely painful and disabling disease in which relief of symptoms is desirable if at all possible. Cortisone very effectively suppresses these disabling symptoms and moreover usually can be given on an ambulatory basis. With this treatment these patients often can resume their usual occupations while recovering from the disease. The results in the present series confirm the impressions of other writers that cortisone is the treatment of choice for subacute thyroiditis at the present time and that prolonged administration for symptomatic suppression is clinically justified.

## SUMMARY

The clinical and pathologic features of subacute nonsuppurative thyroiditis have been reviewed. This condition is usually diagnosed on the basis of the clinical symptomatology, tender thyroid enlargement, and marked elevation of the sedimentation rate. In selected cases needle biopsy may reveal the pathologic diagnosis and obviate the need for surgery.

Subacute thyroiditis is a self-limited disease lasting a few weeks or months but may be severely disabling. Formerly the most beneficial treatment was roentgen therapy. In recent years cortisone has been found to relieve the symptoms and to resolve thyroid tenderness and swelling. Ten cases of subacute thyroiditis in the present series all responded satisfactorily to cortisone administration. However, disabling symptoms may recur on premature withdrawal or reduction of cortisone dosage. Thus, cortisone therapy is apparently only suppressive of symptoms and may not actually shorten the course of the disease.

Sedimentation rates were checked frequently in the present series and served to indicate inflammatory activity. Cortisone therapy was continued in as low dosage as possible for symptomatic suppression until the sedimentation rates returned to normal. Thus, it would seem that cortisone is the treatment of choice for subacute thyroiditis at the present time.

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# The Development of the North Central District Blood Bank Clearing House

**Paul Van Pernis, M.D., Rockford**

IN THE fall of 1954 the American Association of Blood Banks announced a plan for a system of clearing houses for blood. Five districts were set up with the Middle West area being called "The North Central District" and Dr. Coye Mason of the Clearing House Committee was appointed as counselor for the district. Dr. Mason invited representatives of blood banks in the area to a meeting in Chicago after having obtained sponsorship and financial backing for the undertaking from the Illinois State Medical Society. At this meeting a five-man By-laws Committee was elected and instructions to obtain a nonprofit charter in the State of Illinois were given to Dr. Mason. In November the blood bank group met again and the purposes of the corporation were outlined as follows:

A. To establish, maintain, and operate a Clearing House among such blood banks, either now, or as existing, or hereafter created, as may wish to become affiliated with this Corporation for that purpose; and to supervise or handle any transfers or exchanges of blood or blood products between or among any such blood banks, to the end that maximum utilization may be made of all blood and blood products within the area served.

B. To own, deal with, and dispose of real and personal property, and to engage in any and all lawful activities which can or may enhance or further the effective operation of the Corporation as a Blood Bank Clearing House.

On January 26, 1955 the By-laws Committee presented their deliberations and the By Laws were adopted by some 40 representatives of blood banks in the area. Two classes of membership in the Clearing House were set up called "Participating Members" and "Co-operating Members". Participating Blood Banks are those independently operating blood banks and Red Cross Regional Blood Centers licensed by the National Institutes of Health. The Co-operating Blood Banks are those blood banks which are not

*Presented at the fifth Annual Meeting of the Illinois Association of Blood Banks, May 20, 1955.*

licensed by the National Institutes of Health. There is no membership fee. The Clearing House will be financed and the $6,000.00 noninterest bearing loan from the Illinois State Medical Society will be paid by "transaction fees of 50 cents on each transaction between the sending bank and the Clearing House and receiving banks and the Clearing House. Based on the experience of the California and Florida State Clearing House systems there will be little shipment of blood and the transactions will involve mainly the transfer of blood credits. What blood that will be shipped will be mainly across state boundaries and of course will be done by N. I. H. licensed banks.

An interim board of voting directors representing the 11 states of Illinois, Iowa, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, and Wisconsin, and the regional Red Cross centers was elected. The American Hospital Association has been invited to designate a board member to represent them. In addition each state was invited to name a non-voting board member for liaison purposes with the various State Medical Societies.

The first meeting of this interim board was held in the council rooms of the Illinois State Medical Society on February 23, 1955 and the necessary officers elected. Committees were appointed and they reported at the second board meeting in March. An executive secretary, formerly of the Illinois State Medical Society's Public Relations Office was hired and the office opened on April 1 in room 1902 at 185 North Wabash Avenue in Chicago. The Secretary spent a week's training period with the California State Clearing House and we are pleased with her grasp of the tasks before us.

At the April meeting of the interim board committee, reports were heard and necessary actions taken. The value of a unit of blood (500 cc.) was established at $14.00 for Clearing House purposes and the value of processing a unit of blood was established at $10.00.

In the near future you will receive, as will some five hundred other blood banks in the other ten states, a letter of invitation to membership together with copies of the by-laws and the necessary forms. As members of the Illinois Association of Blood Banks you will need to elect a member of the Association to represent Illinois on the regular board for a term of one year. Next year you will need to elect a board member for a term of three years.

We envisage that the Clearing House will minimize the present difficulties of supplying patients' blood needs in any part of a given city, state, or of the nation at the lowest possible cost since it is a nonprofit corporation. We believe it to be a vital part of the proposed National Blood Foundation of the American Medical Association, American Hospital Association, American Association of Blood Banks, American Society of Clinical Pathologists, and the American National Red Cross. This organization should stimulate the formation of Blood Bank Associations in those states not now having such an association. Not only will it aid in the economics of blood banking but will result in better quality and control of the human product for the human being we serve. It will enable us, in time, to know where aid is needed or obtained from in disasters of whatever source. We sincerely solicit your participation and aid in this project.

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# Modern Ophthalmic Therapy by ACTH and Similar Compounds

**Donald J. Boles, M.D., Chicago**

IN the last five years, ophthalmic therapy has undergone a revolution with the introduction of ACTH, cortisone, and hydrocortisone. These hormones have been particularly important because inflammatory reaction to a disease process frequently destroys the function of eye tissues. These drugs do not cure the disease process but block the inflammatory reaction at the tissue level. The exact mechanism by which this is accomplished has not yet been explained completely.

ACTH was the first to be used to inhibit inflammatory reaction. Because it is given to stimulate the adrenal cortex, it must be administered systemically. Cortisone and hydrocortisone inhibit inflammatory reaction at the tissue level and are effective when instilled topically into the eye. Local therapy obviates any undesirable side effects of systemic administration and, at the same time, provides a high concentration of the drug in the eye, especially the anterior segment. Because of this direct action on inflamed tissue, therapeutic emphasis has been placed on cortisone and hydrocortisone rather than an ACTH with its indirect action stimulating the adrenal cortex.

Extensive experimental and clinical studies have been made to determine the relative value of systemic and local administration of the drugs. Cortisone is effective locally in milder inflammations of the anterior segment. In more severe conditions, combined systemic and local therapy are recommended. In inflammation of the posterior segment, local and systemic cortisone should be combined. Hydrocortisone acetate appears more effective when instilled locally into the eye rather than when used systemically, because of its solubility. Hydrocrotisone is only one-seventh as soluble as cortisone in blood plasma. Slower absorption of hydrocortisone is noted when it is injected subconjunctivally.

*Presented before the Section on Eye, Ear, Nose, and Throat, Illinois State Medical Society, 114th annual meeting, Chicago, May 18, 1954.*

There is some clinical evidence that hydrocortisone is more effective than cortisone. However, this is difficult to judge as eye inflammatory processes vary greatly from person to person and even from time to time in the same person. Some authors have reported cases that were benefited by hydrocortisone when cortisone failed.

It has been suggested that hydrocortisone be used locally and cortisone systemically as there is no contraindication to their use together. The average ophthalmic dosage of cortisone and hydrocortisone has been worked out for the various methods of administration. When used as eye drops, either as a 0.5 or a 2.5 per cent solution, a drop is instilled into the eye as often as every hour. As the inflammatory reaction subsides, the frequency of the instillation is decreased.

When injected subconjunctivally, 0.5 cc. of a solution of 25 mgm. per cc. is used. To prepare the eye for the injection, three or four drops of a 0.5 per cent solution of tetracaine hydrochloride may be instilled first. Then, a small applicator well soaked in a 4 per cent solution of cocaine hydrochloride is applied to the conjunctiva where the injection is to be made. The drug may be injected beneath the conjunctiva either above or below the limbus. The injection causes little discomfort. Subconjunctival injection may be repeated every six or seven days.

By mouth, cortisone usually is given in 25 mgm. doses every four hours around the clock. Here again, the dosage is decreased or increased according to the response and the severity of the inflammatory reaction. ACTH is given subcutaneously in doses of 20 to 50 mgm. every six hours.

ACTH and cortisone systemically are contraindicated in diabetes mellitus, congestive heart failure, hypertensive cardiovascular disease, Cushing's syndrome, acne, hirsutism, osteoporosis, osteomalacia, and in active tuberculosis and peptic ulcer, or where there is a history of either.

Although in many conditions, the response to steroid therapy is questionable, there is general agreement regarding the specific indications for these drugs. Table I briefly outlines the inflammatory reactions benefited by ACTH, cortisone, and hydrocortisone.

Table I

Ophthalmic Conditions Benefited by ACTH, Cortisone, and Hydrocortisone:

A. Inflammatory reactions involving the conjunctiva:
   - Allergic conjunctivitis
   - Vernal conjunctivitis
   - Chronic nonspecific conjunctivitis

B. Inflammatory reactions involving the cornea:
   - Recurrent marginal corneal ulceration
   - Nonspecific superficial keratitis
   - Phlyctenular keratoconjunctivitis
   - Acne rosacea keratoconjunctivitis
   - Deep keratitis
   - Herpes zoster ophthalmicus

C. Episcleritis

D. Inflammatory reactions involving the uvea:
   - Acute iritis and iridocyclitis
   - Chronic iritis and iridocyclitis
   - Acute choroiditis and chorioretinitis
   - Chronic choroiditis and chorioretinitis
   - Postoperative uveitis
   - Sympathetic ophthalmia

Allergic conjunctivitis: Some of the most dramatic results have followed the local use of cortisone or hydrocortisone in this condition, either in solution or as an ointment. A solution of a combination of cortisone and an antihistaminic product has given encouraging results. It must be borne in mind that adrenal cortical steroids do not cure allergy. Removal of the allergen, where possible, and desensitization, remain the proper treatment of allergic conjunctivitis.

Vernal conjunctivitis: The response to ACTH, cortisone, and hydrocortisone has been encouraging. Control of severe inflammatory reaction is important during the season when symptoms are present. In the more severe cases, systemic treatment must be combined with topical application.

Chronic nonspecific conjunctivitis: Where exhaustive research reveals no specific etiology, cortisone and hydrocortisone have relieved symptoms. In these cases, hydrocortisone seems to be more soothing.

Recurrent marginal corneal ulceration: In some of these cases, sensitivity to staphylococcus toxin was found. Cortisone or hydrocortisone instilled topically brought rapid recovery. A local antibiotic also was used in conjunction with the steroid. Various pharmaceutical companies manufacture preparations containing cortisone or hydrocortisone combined with broad spectrum antibiotics. A word of caution should be given. Indiscriminate use of adrenal cortical steroid-antibiotic compounds should not be substituted for careful etiological study, but used only after they are indicated by the diagnosis.

Nonspecific superficial keratitis: In this group of conditions, the etiology is vague and many treatments have been tried.

Phlyctenular keratoconjunctivitis: Whether tuberculin sensitivity exists or not, cortisone and hydrocortisone have brought rapid recovery. However, when the drug is stopped, the condition tends to recur.

Acne rosacea keratoconjunctivitis: The response to hormonal treatment has been dramatic. Usually, both systemic therapy with ACTH and local therapy with cortisone are employed. After acute symptoms subside, systemic therapy is stopped but local therapy is continued for a long period. Sudden stoppage of local instillations of cortisone has been known to precipitate relapse.

Deep keratitis: The sclerosing type of keratitis responds well to combined topical and systemic cortisone. The response of the classical syphilitic interstitial keratitis seems to be related to the time when treatment is started. Best results are obtained when treatment is started early in the course of the corneal involvement. Cortisone, both systemic and topical, is used as well as the usual antiluetic therapy.

Herpes zoster ophthalmicus: This condition involves not only the cornea but the conjunctiva, uveal tract, and the various layers of the eyelid. Evidence indicates that systemic and local cortisone therapy decreases the severity of the inflammatory reaction, but not to the degree indicated in some of the earlier reports. Evaluation of the effect of steroid therapy in this condition is difficult because of the marked variation of herpes zoster in different patients.

Episcleritis: This condition has responded well to cortisone and hydrocortisone. Usually topical application brings symptomatic relief.

Evidence indicates that response to hydrocortisone is more rapid.

Acute iritis and iridocyclitis: Nowhere have the cortical steroids proved more effective than in acute inflammation of the anterior uvea. Particularly important is the prevention of the formation of synechia with subsequent secondary glaucoma, seclusion of the pupil, occlusion of the pupil, and iris bombe. Treatment should be both systemic and topical. As inflammation subsides, systemic treatment is stopped but local treatment is continued until all signs of inflammation disappear. In mild cases, topical application is sufficient to control inflammation. Mydriatics, fever therapy, local heat, and the other usual measures are used in conjunction with cortisone and hydrocortisone.

Chronic iritis and iridocyclitis: Hydrocortisone and cortisone seem to be of some value in controlling the severity of this condition. Topical applications must be continued for long periods and dramatic results are not to be expected.

Acute choroiditis and chorioretinitis: In inflammation of the posterior uvea, systemic use of cortisone always is necessary. The response usually is good but much slower than it is in the anterior segment of the eye.

Chronic choroiditis and chorioretinitis: Evidence indicates that systemic use of cortisone and ACTH is of limited value in chronic inflammation of the posterior uvea.

Postoperative uveitis: Topical application of hydrocortisone or cortisone have controlled effectively inflammation of the anterior uvea following surgery for cataract and glaucoma. These hormones have been used effectively also in filtration operations to prevent excessive fibrosis. Topical instillation usually is sufficient.

Sympathetic ophthalmia: Combined local and systemic cortisone helped most cases. Local cortisone must be continued for a long time or relapse is likely. A larger series of cases is needed to determine the benefit afforded by the steroids.


**SUMMARY**

1. The anterior lobe of the pituitary gland secretes ACTH, which stimulates the adrenal cortex to produce a number of steroids, two of which are cortisone and hydrocortisone.

2. Cortisone and hydrocortisone inhibit the inflammatory reaction at the tissue level.

3. ACTH must be administered subcutaneously. Cortisone and hydrocortisone may be used locally as eye drops or ointment and systemically by mouth or subcutaneously by injection.

4. ACTH and the systemic use of cortisone are contraindicated in diabetes mellitus, congestive heart failure, hypertensive cardiovascular disease, Cushing's syndrome, acne, hirsutism, osteoporosis, osteomalacia, and in active tuberculosis and peptic ulcer, or where there is a history of either.

5. Adrenal cortical steroids are effective in the treatment of ocular allergies and inflammation of the cornea, anterior uvea, and posterior uvea.



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## Prolonged pregnancy

Case reports were obtained from 5,000 patients by means of a personal interview during the first week of the puerperium. These reports showed that in 53.1 per cent of single vertex presentations, labor began spontaneously during the 40 or 41 week of pregnancy. In 7.4 per cent, pregnancy was prolonged for more than 14 days after the estimated date of confinement. There was no relationship between the length of the menstrual cycle and the duration of pregnancy, provided the cycle was not unduly prolonged. There was an increase of fetal mortality to 5.1 per cent if pregnancy was prolonged for more than 14 days after the estimated date of confinement. *George B. Gibson, M.B. Prolonged Pregnancy. Brit. M.J. Sept. 17, 1955.*

# Nervous System Disorders in General Practice

F. Garm Norbury, M. D., Jacksonville

SIR Arthur Keith, the great English physiologist, wrote one of the most fascinating books I have ever read. Its title is "Engines of the Human Body." The imprint of the front of the book shows a diagram of a crane and the upper portion of the human femur for comparison. Chapter headings include such items as "muscles as combustion engines," "the output of the heart," "breathing, thinking and health," "automatic nerve exchanges," and many other showing the application of principles of physics and chemistry to human functions. I took this title and worked on it for a talk as Chairman of the Section in Medicine of the Illinois State Medical Society in 1942. I also drew freely from Sherrington's "The Integrative Action of the Nervous System" in that talk. I have a purpose in referring to these monographs.

Every physician whether in general or specialized practice sees patients with psychosomatic disorders daily. Many of these relate to the translation of response to life situations into physical symptoms. Many of them are tied in with the reaction of the patient to physical conditions themselves. Some are quite clear cut in their relationship, some are more obscure, some are farfetched indeed.

The rejection phenomenon of the young woman who finds she is pregnant and does not want to be may well be shown in nausea and vomiting. This may happen to the married as well as the unmarried. Other factors enter the picture. Yet analysis of the story will show this more often the case than not. Such a condition may well go on through development of starvation, acidosis, body chemical changes, renal shut down to the pernicious and sometimes fatal vomiting of pregnancy. Thus can psychological response bring about serious physical changes.

A comparable condition is that of peptic ulcer. Movie magnates who have to fuss with temperamental stars, business executives who have problems to meet, attorneys who are on the wrong side of a tough case, farmers whose plans are upset by drought or storm or market situations get their stomachs out of order. They probably belong to the worrying type of personality. They are bothered, don't want to eat, smoke and drink too much. The greater the stress, the greater the vagus nerve stimulation, the greater the outpouring of acid, the greater the spasm of the arteries in the ulcer bearing area. First comes the congestion, then the erosion of an area of mucus membrane. The stage is set. The protective mechanism that normally keeps the gastric juices from acting on the stomach lining is broken down. Erosion, spasm, hyperacid gastric juice produces the clean cut ulcer. If not controlled this may extend to involve a branch of the gastric or pancreatico-duodenal artery. Whoosh — a hemorrhage. The erosion may keep right on eating through an ischemic area and through the serosa — then perforation. This rarely occurs with the first session of an active ulcer but as we all know ulcers tend to recur. Often it is only by careful history that one can find out when the patient probably had his first active session. Sometimes one does not find out through the history of digestive symptom but only makes the discovery through the story of a stress condition "when my stomach got all upset." Ulcer is a striking instance of how early psychologic stress may develop really a habit spasm that can advance to serious and again sometimes fatal consequence.

Dr. Bertram Sippy of Chicago popularized a treatment of ulcer that was largely mechanical in its application, yet it had the important element of six weeks' hospital rest away from business and family cares as part of the treatment. His theory of constant neutralization of acid with soda bicarb, and midnight aspiration made most internes on medical services during this period stay up late. It has been largely revised with greater understanding of gastric physiology

*Given before the Clinton County Medical Society, Breese, Illinois, April 13, 1955.*

but some of the principles still hold. The work of Wolff and Wolff on direct observation of gastric mucosa in their patient "Tom" showed the effects of emotion on secretion. Beaumont observed comparable reactions on his patient Alexis St. Martin so clearly described in his monograph and outlined in Osler's essay "A Pioneer Physiologist."

Dr. Sippy also brought to the attention of physicians another condition that plagues us all. He called it the irritable bowel. Radiologists call it spastic colon. When accompanied by excretion of mucus some still call it mucus colitis. Others call it spastic constipation. Cramplike pains in the abdomen, usually increased under nervous stress, and constipation that may hold up 'bms' for several days are in the picture, then comes an evacuation and diarrhea comparable to the dumping phenomenon sometimes seen after gastroenterostomy. Patients feel all in after this. I have seen two in consultation recently who fainted by reason of unstable blood pressure, congestion in the abdominal viscera and a severe letdown. These were both women, had had stresses that were too much for them. The son of one of them had married and left the home. She did not want to let him go. He went. She then would not let other things go. Result was constipation and the chain of symptoms described above. When this was explained to her and her husband and the idea put across it was accepted and a six months' illness cleared in a week. The other patient had had to have a Cesarean section. The baby died. The couple was much upset, the wife naturally more so. It was difficult for her to let go of the idea of having a baby. She translated that to not letting go of anything. Explanation eventually straightened that out. These may seem farfetched but they are factual and not the result of any deep psychoanalysis but simply of search and an explanation. Organic concomitants had been previously ruled out in both instances.

An engine of the body that has strong feeling tone associations for all of us is that pump, the heart. Since disease of it is public enemy No. 1 as regards cause of death it is only natural that the public has great awareness of it. I have been working for several years at a paper on the emotional connotations of the word heart. From childhood, study of physiology in school, through song and story, myth and fable, religion, science and news columns something referable to the heart is thrown at us every day. By reason of the importance attached to it for continuity of life anything that makes us aware of heart function or dysfunction develops significance. That is not by any means intended to minimize organic heart disease. It only serves to emphasize the need for careful diagnosis and planned management whether serious cardiac conditions prevail or disturbing but not dangerous heart consciousness is in the picture. There is no phase of medicine where the general practitioner can be of more help to his patients in diagnostic understanding and program planning than in dealing with cardiac patients.

Along with and intimately associated with cardiac conditions and their relation to the nervous system comes the problem of hypertension. Hypertension is one of the common conditions seen in general practice. The question of which came first, the chicken or the egg has an association here. The relationship is more through the autonomic nervous system with emphasis on the sympathetic rather than the parasympathetic divisions. Impulses affecting each of these divisions come down from the brain. The hypothalamus is that part of the brain where there are representations of the autonomic nervous sysem. It is thought by many to be the relay station for this system. One set of nuclei affects sympathetic, another set affects parasympathetic response. Pressor effect producing spasm of blood vessels is sympathetic in origin. Tension, drive, anxiety, fear, all increase sympathetic response; thereby elevate blood pressure. If this gets to be a habit pressure remains elevated. This in time can produce definite structural effects on the vessels, also throws an extra load on the heart.

Drugs introduced in recent years for hypotensive effect all affect the nervous system response, either central or peripheral. We must all remember that hexamethonium salts and ansolysen act as ganglionic blockers of impulses in the sympathetic chain. We need to realize that veratrum products have their effect through reflex dilatation of blood vessels. We should recall that hydralizine or apresoline brings about its results through central action as well as renal vessel dilatation.

Reserpine (serpasil) and any of the rauwolfia preparations exert their influence probably through the hypothalamus and the reticular substance in the pons. The tranquilizing effect reported by many and summarized in our Sanatorium blotter for February 1955 is the action that makes such preparations so useful in neuropsychiatric as well as hypertensive states. If one lessens the push by cutting down on sympathetic stimuli from the hypothalamus there is going to be less arterial spasm, hence blood pressure is lower. The chance of structural change should be lessened.

This brings us to the second portion of this talk for cardiac and hypertensive conditions, both functional and organic, are a part of management of people in the older age group. As more people live more years the practice of many of us, except obstetricians and pediatricians, is now and will become more involved with these individuals.

Osler said the time to treat arteriosclerosis is twenty years before the patient begins to show symptoms. Research studies would now lead in many instances to a longer period than that. The octogenarian who said the reason he was so well at 80 plus was because he picked good ancestors really had something in the light of genetic studies. Many of us in this room have a chance these days to live to be 80. The thing that is important to us and to our children who may have to look out for us is what kind of people will we be at 80.

No one, doctors least of all because we see all too often the tragic side of advancing years, wants to live to be 80 and be physically or mentally incapicitated. What can we do about it? That is our job as more people ask us that question. I am enough of an optimist and not enough of a therapeutic nihilist in the broad sense to think that something can be done about it.

This sort of thing does not happen to everyone. You have a classic example in the Secretary of your own society of a doctor who has retained physical and mental vigor and whose activity belies his years. During the time I was councillor in my district and during this year in my present situation I have attended Fifty Year celebrations and community celebrations for doctors. I have been struck with certain characteristics these physicians present. First of all they probably chose their ancestors well. Next they had interests outside their profession. Then they were conscientious sincere individuals who worked at their job. Finally and most important of all to me (being interested in neuropsyhchiatry) they possessed what Osler described in his essay "Aequanimitas." Even with intense personalities and strenuous activity they had developed equanimity, an even tempered power of relaxation, tolerance and understanding. I only hope I too can attain that as time marches on.

Personality factors therefore enter into arteriosclerosis. The most tragic results come about through changes in the central nervous system. True, arteriosclerotic heart disease, chiefly coronary disease, is more common, often more dramatic. Arteriosclerotic renal disease and peripheral vascular disorders take their toll too. Cerebral vascular disorders with or without hypertension, with major paralyses or little strokes, with capillary fibrosis, with premature deposition of plaques as in Alzheimer's disease, are responsible for much mental illness. A state hospital superintendent told me that sixty-two per cent of their admissions were due to psychoses with cerebral arteriosclerosis.

One of the earlier signs of impending cerebral anteriosclerosis is emotional lability, rather sudden and often unpredictable changes in the feeling tone of the person.

This antedates the more marked stage of instability. The patient himself frequently recognizes the lability or shifting, usually toward the depressed side. He may come in about some other condition, an intercurrent infection or gastrointestinal disorder. In the course of conversation a statement like this is often made, "Doctor, I get upset more than I used to." "Things worry me more even though there is no cause."

If this is picked off, recognized and a satisfactory explanation given and which the patient will accept, it is my firm belief that something has been done to slow down the progressive changes for that individual. Other things may need to be done too. I remember well a fine minister in our community who first consulted me about such symptoms. Inquiring and examination brought out the story of big Sunday dinners at homes of different parishioners, bad

elimination the next day. This was in the time of the popularity of ricinoleic acid as a detoxifying agent. It is an active ingredient related to castor oil. Ricinoleic acid preparations were expensive. Ministers did not have big salaries. Castor oil is cheap. This fine gentleman, though now retired as a minister, is still quite active and still takes castor oil once a week. Louis Faugeres Bishop, one of the great cardiologists of New York, prescribed castor oil regularly for his angina patients. I prescribe it for many of my patients. Old fashioned, yes, but I believe it works in such situations. We have had numerous older patients in the Sanatorium with mild toxic deliria for whom rest and castor oil have been the therapeutic measures.

When emotional lability has extended to emotional instability more definite measures are indicated both in diagnosis and treatment. Careful neurologic and psychiatric examinations, including perhaps some psychologic tests, are needed. One wants to find out whether the "little strokes," the "gravy on the vest" type of reaction has occurred. These may have happened without pronounced decrease of mental capacity in business or profession or homelife. They call for understanding on the part of patient, family and associates and for protection without obvious limitation. Correction of physical disorders, dietary regulation, sufficient rest are general measures. Vasodilators such as aminophyllin, though decried by some, are helpful I think. We have not seen much benefit from metrazol or coramine where underlying general circulatory dysfunction is not present. Vitamins particularly the reinforced B complex preparations are definitely helpful. The newer tranquilizing drugs, chlorpromazine and reserpine are definitely helpful.

My father used a comparison as regards management of either mild or pronounced cerebral arteriosclerotic conditions that has been most helpful to me. I have used it often in talking to patients or families. People with such an illness are like those who cannot swim. They get along fine in shallow still water. When in deep water, over their heads, or buffeted by waves, they are in serious trouble, perhaps in danger to themselves or others. Therefore, the cerebral arteriosclerotic patient should not venture into activities beyond his capacity or be subjected to situations that may throw him over. Recognition of these limitations and advice about them is the responsibility of the physician. Careful evaluation and appropriate treatment often brings about excellent results.

The condition may have progressed, nevertheless, to a stage wherein a definite cerebral accident has occurred. The job then is one of salvage, of restoration of function, of rehabilitation. We all have read of Sir Winston Churchill's comeback after strokes, one of which affected his speech greatly. The inherent drive of the patient has much to do with this as it did for him. If that drive is not there we must endeavor to insert it. Early ambulation, physical therapy are important also. I have been much impressed through quite close personal contact with how much an individual can accomplish. I visited the Institute of Physical Rehabilitation at St. Frances Hospital in Peoria recently and saw excellent results there. Finger board, shoulder wheel, parallel bars, steps, guide rails plus the important *will* on the part of the patient and physician lead to return of even finer coordinated movements in many people with major strokes. Stimulation of the intellect, not allowing contractures in it any more than not allowing contractures of paralyzed extremities, is another medical responsibility. This is time consuming, it is not dramatic, but it pays off in results. One has to be something of a fatalist but there is in my opinion no excuse for being a nihilist in this field of therapy.

The really distressing conditions are those of the repeated little strokes with resultant capillary fibrosis and cerebral atrophy. Protection and care are the elements of treatment here. Yet even in these poor people some surprising things happen. Often they happen because the higher levels of emotional response are shut off. There is a lower level of capacity but it is still pretty good within limitations. Consequently the patient can have some enjoyment out of life. The family being well briefed and being understanding (we hope) gets along better. Chlorpromazine has helped many of these patients to get back into the home environment and to hold up until further extension or a major episode ends the story.

Hospitalization is, of course, necessary in many situations for various reasons. We have often heard comments from relatives about how

comfortable a patient appears to be, when at home or in a general hospital there has been more or less continuous disturbance. The answer is relatively simple. First, is the controlled shallow water type of environment with protection from buffeting waves of extraneous stimuli. Second, is that in that type of environment where there are others in similar condition sedation which in itself often causes confusion can be minimal. With no intent at all of ascribing any religious application, though that phase enters in also, it may prehaps be compared to the sanctuary motivation for relief of distressed people in older times.

So whether nervous system disorders be psychosomatic or organic they represent the response of the patient as a whole to life situations. The physician in general practice knows more about the life situations of his patients than anyone else. He is in a position to see illness in its early phase, guide the response, conserve the nervous energy, cure many, help many others, help families to understand how these things came about and how to protect the patient. That is a worth-while effort for any one of us.

The Norbury Sanatorium

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## A student's dream

Probably only a medical student cramming for an examination would be likely to dream seriously of a machine which could make a diagnosis if given a set of symptoms. Obviously no machine can do this but it can help, as a description by Nash in the Lancet attests. He has invented a sort of slide rule which matches symptoms against the names of 300 diseases, thus condensing a huge volume of information on differential diagnosis on one small surface.

The device consists of a frame with a disease reference index fixed at one side, representing one disease beneath the other, in alphabetical order. The frame has space for inserting a number of detachable longitudinal strips, each representing one symptom. Each strip is marked to correspond, when inserted into the frame, with the diseases that symptom accompanies. The name of the symptom is printed at the bottom end of its strip, and matching reference numbers on the frame and the movable cursor are a help when the device is being used. A typwritten list of 300 diseases measures about 4 feet 2 inches; by photographic reduction this can be made into a scale 2 feet long, and further reduction to a length of only 18 inches is practicable.

To correlate a number of symptoms with a particular disease category or categories, the symptom strips fitting the patient's case are selected from their storage place and inserted, one beside the other, in the frame. It will then appear that each symptom has its own spectrum or pattern of causation; in some places two or more of the horizontal markings will lie opposite the same disease, in a straight horizontal line, extending across several or all of the symptom units opposite that disease. The patient's disease, must be one of those that would account for all or most of his symptoms, as can be seen at a glance. It can also be seen which disease would explain some of his symptoms but not others. The diseases having the longest horizontal composite lines pointing to them would be the ones to consider as possible diagnoses in that particular case. It is intriguing. the author points out, how many causes the apparatus can suggest for one or two of the patient's signs or symptoms and how, as more and more of his symptoms are inserted, the range of possibilities rapidly narrows. *Diagnosis by Slide Rule? What's New (Summer)* 1955.

# Nausea and Vomiting of Pregnancy

## Preliminary Trial of Bonamine in Sixteen Patients

HOWARD M. SEIDNER, M.D., CHICAGO

THE syndrome of nausea and vomiting of pregnancy has always presented a difficult therapeutic problem. The qualities to be desired in a therapeutic agent are a high order of efficacy, prolonged duration of action, and absence of untoward effects.

Factors that have impelled continuing research in the management of this syndrome are its high incidence, variously estimated as occurring in 50 to 80 per cent of all pregnancies, and its potential seriousness, as symptoms may vary from simple morning sickness to pernicious vomiting that may end fatally. Therapeutic experimentation has been handicapped by a lack of clear-cut etiologic knowledge. Apparently a variety of causative factors may be operative, either alone or combined, depending upon the individual case. Hunger, nutritional deficiencies, emotional stress, and endocrine changes are generally believed to be the most important of these factors.

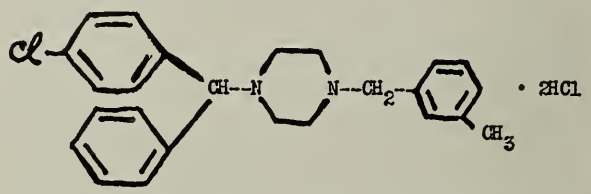
Therapy directed along one or more of the lines suggested by these etiologic considerations is successful in some cases but fails in a significant number. Simple reassurance and the use of sedatives may be useful when the emotional element (anxiety and apprehension) is prominent. A well balanced diet that caters to the patient's desires and provides frequent small feedings may be helpful. Pyridoxine (vitamin $B_6$) apparently is effective in some cases. In the many cases not benefited by any of these measures, however, vomiting may become progressively more severe, necessitating hospitalization for parenteral hydration and alimentation.

### CHOICE OF A THERAPEUTIC AGENT

The most promising approach to therapy has been provided by recent research demonstrating the effectiveness of some of the antihistaminic compounds used in the prevention and treatment of motion sickness. Compounds of this type have been tried with varying degrees of success in the treatment of nausea and vomiting of pregnancy.

Strode and Amster[1] reviewed the literature on motion sickness research and find compelling evidence of the superiority of Bonamine®* over other agents used against motion sickness. It is a "drug that in a single, small dose affords maximal protection over a long period of time with minimal side effects." Equally favorable results in nausea and vomiting of pregnancy have been reported by Bass[2] and McKenna.[3] Complete symptomatic relief was obtained in approximately 90 per cent of patients treated with Bonamine; a single daily dose of 25 or 50 mg. was fully effective in most cases and side effects were remarkably few.

Bonamine is a fairly recent addition to the list of antihistaminic compounds. It is designated chemically as *p*-chlorbenzhydryl-*m*-methylbenzylpiperazine dihydrochloride and has the following structural formula:




P'an, Gardocki, and Reilly[4] demonstrated the prolonged duration of action of Bonamine in pharmacologic studies. Bonamine was shown to be considerably less toxic than other antihistaminic products, including dimenhydrinate, which was studied comparatively.

### CLINICAL TRIAL

The patients included in this trial of Bonamine were 16 women suffering from nausea and vomiting of pregnancy. Therapy was initiated during the second or third month of gestation with the exception of one patient who began therapy as late as the 22 week. All patients received the drug in a dosage of 25 mg. (one tablet) once daily upon arising. In one case it was found necessary to increase the dosage to 25 mg. twice daily (upon arising and again at bedtime) to afford complete relief.

*Bonamine (brand of meclizine hydrochloride) was supplied for this study by the Medical Department of Pfizer Laboratories (Division, Chas. Pfizer & Co., Inc., Brooklyn, N. Y.)

Every patient, except one, was completely relieved. The remaining patient experienced excellent control of vomiting but suffered occasionally from slight nausea. There were no effects in any of the 16 patients.

These results compare favorably with those obtained by Bass[2] who used Bonamine on 182 women suffering from nausea and vomiting of pregnancy and reported that "98.5 per cent of the patients were benefited, with 90 per cent obtaining complete relief". Only 3 cases were considered therapeutic failures.


**SUMMARY**

Bonamine therapy in 16 patients with nausea and vomting of pregnancy gave complete relief in 15 cases (95 per cent). The remaining patient, although relieved of vomiting, continued to have occasional episodes of slight nausea. In only one instance was it necessary to give more than a single 25 mg. dose of Bonamine daily to provide freedom from symptoms throughout the entire 24 hours. No side effects were noted in any case.



104 S. Michigan Ave.


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## Chemotherapy in measles

The observations recorded in this paper indicate that in a great many patients with measles, antimicrobal therapy not only is ineffective in preventing bacterial complications but also may increase the risk of their development. Since, in addition, infections occurring during chemoprophylaxis may be due to organisms that are relatively drug resistant, and since the administration of any of the antibiotic agents is accompanied by a varying risk of some type of reaction, it appears not only unnecessary but also possibly even unwise to administer chemotherapeutic agents to patients with rubeola until there is definite evidence of a treatable secondary bacterial complication. Antimicrobal substances often are given, not for the purpose of prophylaxis but rather for treatment in the prodomal phase of measles, under the mistaken impression that symptoms are due to bacterial infection. It may be very difficult to distinguish between the two without laboratory studies, which may be difficult to carry out; a history of exposure to measles is helpful but not entirely conclusive. The decision must rest entirely upon the judgment of the physician, who is aware of the risks involved in the use of antibacterial agents. Unfortunately, however, parents and patients often insist upon the use of antibiotics in the presence of fever or what appears to be respiratory tract infection, and it may be difficult for the physician to refuse this demand. *Louis Weinstein, M.D. Failure of Chemotherapy to Prevent the Bacterial Complications of Measles. New England J. Med. Oct. 20, 1955.*

# Sympocaine (Win 3706), A New Regional Anesthetic

Mary Karp, M.D., and Leonard Peal, M.D., Chicago

This study is a clinical report on a new regional anesthetic agent: Esters of para-amino-benzoic acid in which the hydroxy group is in the 2- positions is replaced by various alkoxy side chains have been shown to have local anesthetic qualities.[1] The addition of a 2-butoxy group to procaine gives a compound 2-Diethylamine ethyl 2-amino-2-butoxybenzoate hydrochloride-designated Sympocaine® (Win 3706)*. Studies have shown this compound to be as active as tetracaine in prolonging sciatic nerve block in guinea pigs and to be only one-quarter as irritating.[1] Sympocaine also was shown to be 20 times more active than procaine in producing sciatic nerve block in guinea pigs or spinal anesthesia in rabbits.[2] In addition this compound showed considerable activity by topical application. The results of these studies warranted a clinical trial of this drug.

Sympocaine is a white crystalline powder which melts at 125.4 to 126.4° C. It is soluble in water to the extent of at least 20 per cent. The pH of a 1 per cent aqueous solution is 4.6 and no precipitation occurs when a solution is adjusted to a pH7.0 with N/10 NaOH

Previous studies have shown this compound to have a low incidence of toxicity reaction and a high procaine ratio—22. In comparison to the procaine ratio of tetracaine HC1 as 9.2 and lidocaine as 2.2 Sympocaine is about 10 times as potent as lidocaine and 2 times as potent as tetracaine HC1.[2]

The types of cases chosen for this study were a cross section of surgical procedures. (Table 1.) Spinal anesthetics of both the hypobaric (25 cases) and hyperbaric (47 cases) types were done and the levels varied from saddle blocks to T3. Patients were examined postoperatively every 10 minutes until all signs of anesthesia were abolished, and then twice daily while they remained in the hospital. All postoperative anesthetic sequelae were indicated on the chart.

The dosage for the hypobaric anesthetics ranged from 5 mg. to 14 mg. and for hyperbaric from 2.5 mg. to 13 mg. These dosages corresponded closely to those used when tetracaine HC1 was the anesthetic agent. The duration of operative procedures varied from 5 minutes to 95 minutes in surgical cases and from 30 to 120 minutes in obstetrical cases. Adrenalin was used when it was thought the time would exceed 60 minutes. Usually 0.2 cc. of adrenalin 1/1000 was used. The onset of anesthesia varied from 10

TABLE 1

| Type | Number Of Cases |
|---|---|
| Cesarean sections | 3 |
| Deliveries with epesiotomies | 25 |
| Hysterectomy | 1 |
| Retained placenta | 1 |
| Inguinal hernia bilateral | 2 |
| Transurethral resections | 5 |
| Perineal prostatectomies | 1 |
| Pyelolithotomies | 2 |
| Moore prostheus | 2 |
| Renal exploration | 2 |
| Retropubic prostatectomy | 1 |
| Nephrectomy | 2 |
| Hemorrhoidectomy | 15 |
| Vaginal examination | 1 |
| Suprapubic prostatectomy | 2 |
| Suprapubic cystotomy | 1 |
| Renal cyst | 1 |
| Anal fissure | 1 |
| Spinal fusion | 1 |
| Bladder tumor | 2 |
| Reanastamosis of Vas | 1 |

*Department of Anesthesia, Chicago Wesley Memorial Hospital, Chicago, Illinois.*

*Division of Surgery Northwestern University Medical School, Chicago.*

*This work made possible through grant from Winthrop-Stearns, Inc.*

*Sympociane (Win 3706) Winthrop-Stearns, Inc., New York.

seconds to 240 seconds with an average of 64 seconds. The variation and time of onset did not seem to be determined by the dosage or its concentration.

During the procedures the following untoward reactions were observed; eleven instances of nausea; in 8 of these patients it progressed to vomiting. In all there was a concomitant hypotension, in three of which hypotension was most likely due to a high anesthetic level. The blood pressure in each case was well controlled by vasopressor agents. Pain on injection occurred in three cases and nervousness in nine. Postoperatively, the only sequelae were headache in 12 cases, none lasting more than 48 hours. There were no cases of neuralgia, neuritis, meningism, localized pain, hyperesthesia, or hypoesthesia.

In surgical cases, when Sympocaine was used with 0.2 cc. of adrenalin, the average duration of anesthesia was 130 minutes, of analgesia 200 minutes, and paralysis 110 minutes. In obstetrics, where the drug was used without adrenalin, the average duration of anesthesia was 65 minutes, analgesia 90 minutes, and paralysis 29 minutes. The low incidence of paralysis in the latter group was due to the fact that many of the low spinals showed little or no paralysis of the lower extremities. Muscular relaxation was adequate in all the abdominal cases and in no instance was an uncontrollable level encountered. Fixation of the drug usually occurred in 3 to 5 minutes.

**SUMMARY**

A new drug, Sympocaine (Win 3706), was used in 72 spinal anesthetics of various types. It proved to be a satisfactory agent of low toxicity and good potency and gave profound spinal analgesia that was satisfactory as to duration of effect.

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## Liver function tests

The last two decades have witnessed far-reaching changes in the diagnosis of liver ailments. The difference between then and now is so great that the diagnosis in the 1930's could almost be characterized as guesswork.

Physicians today have a number of special tests at their disposal as well as a large accumulation of experience and knowledge gained through observation of liver malfunction. Also, there has evolved a precise terminology in this area, which, with the special tests, make for common understanding when liver conditions are discussed and evaluated.

Despite recent advances, present day tests for liver disease do not cover all conditions, especially minor ones. Some tests give only rough indications, others show up a disorder only after it is irreversible. Test results may be clouded by such nonhepatic disturbances as severe respiratory ailments. Nevertheless, research in this field does hold the promise of improved diagnostic tests in the future. What makes the liver especially significant at the present time is the increase in liver disease since World War II. In part this is due to viruses brought back by soldiers returning from foreign service. Blood transfusions in recent years also have been responsible for some liver ailments. *Franklin M. Hanger. The Clinical Evaluation of the Commoner Hepatic Disorders.*

# CASE REPORTS



# Role of the Bowel in Renal Osteodystrophy

**Charles V. Heck, M.D., Fremont A. Chandler, M.D.*, Chicago**

THE first association of late rickets, albuminuria, and chronic kidney disease can be traced to Lucas[1] in 1883, referred to the triad as "rickets of adolescence." Other authors who contributed cases to the literature in the following years did not always clearly define the type of rickets present, therefore, it is difficult to evaluate early presentations properly. In 1911, Fletcher[2] clearly correlated for the first time renal and bone changes. Barber[3], in 1920, gave an accurate description of the disease pointing out renal damage, dwarfism, and bone changes and suggested the term "renal dwarfism."

The term "renal rickets" and its synonyms denotes basic pathology involving the kidneys and bony structures. Changes in the kidneys may be due to congenital, developmental, or disease causes. The severity of a given case varies widely from similar cases in proportion to the underlying cause thus explaining the great number of terms applied to the condition in the past.

Kretchmer[4] has outlined the major theories thought to explain partially the sequence of events in renal osteodystrophy. However, none of these explanations satisfies all clinical findings.

The "renal theory" assumes that an always present chronic kidney disease is followed by skeletal changes. Mitchell[5] has cited evidence that waste endogenous products are excreted through the intestinal mucosa in the presence of a relative or absolute failure of the kidneys. Repeated demonstrations have shown that an increased concentration of phosphates in the bowel may interfere with absorption of calcium by formation of insoluble calcium phosphates. Calcium starvation may occur when increased phosphorus in the intestine blocks absorption of calcium from ingested food. Skeletal changes which follow are diminution or cessation of bone growth with deformities and enlargement of bones at their endochondral junctions.

Other theories include the parathyroid changes which have been found in both children and adults. Some authors feel that excess secretion of parathyroid hormone causes secondary kidney changes, essentially fibrosis with microscopic calcifications. History is helpful to some extent in differentiating primary and secondary hyperparathyroidism. The pituitary theory is

*From Department of Orthopaedic Surgery, University of Illinois, Chicago, Illinois.*

**Deceased December 24, 1954.*

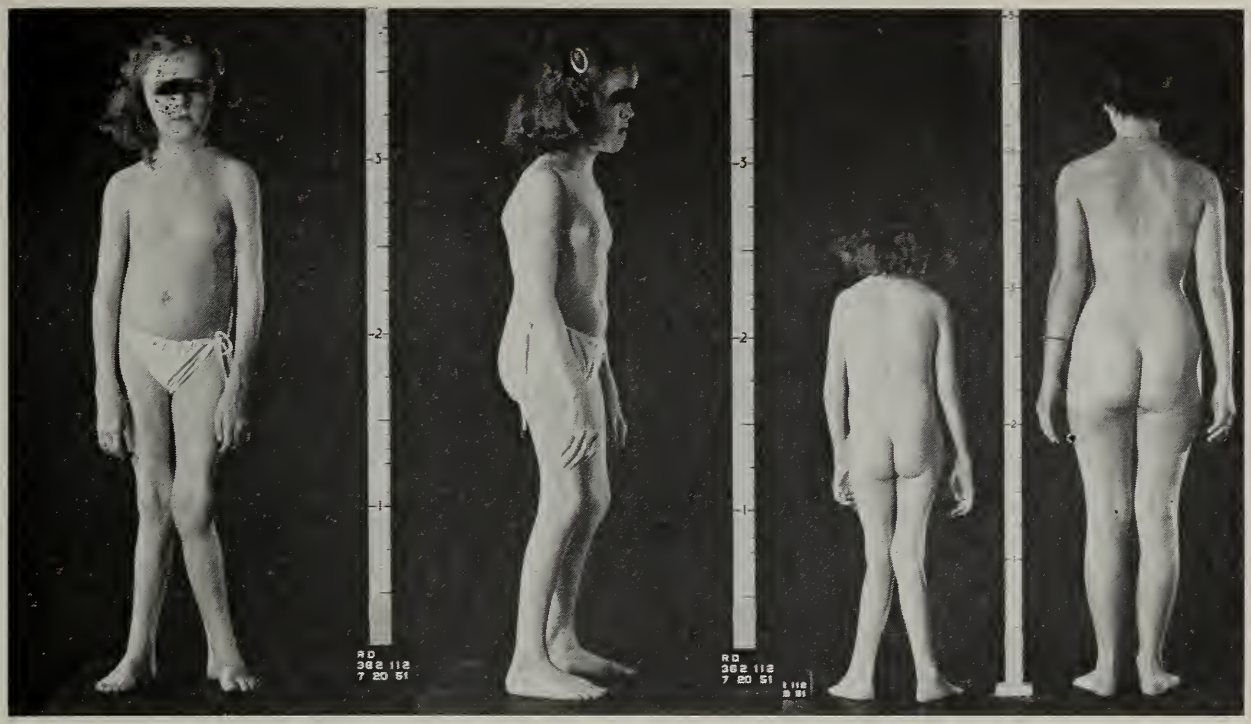


*Figure 1. The two photographs on the left show the posture and stance of the patient. Size is brought out by the two photographs on the right. The normal patient of the same age is on the far right.*

sometimes used to explain such factors of renal rickets as dwarfism, infantilism, and polyuria. Some authors propose that acidosis itself is the direct cause of the syndrome when such acidosis is secondary to prolonged kidney dysfunction.

The following case is presented to show that the bowel plays a role in excreting kidney wastes when kidney function is damaged. We are unable to propose any one theory which will explain the loss of kidney function and regret that no postmortem examination was done when the patient succumbed in another state a few weeks later.

R. D. Age 14. This patient, with 11 normal siblings, was admitted to the hospital because the parents were concerned with her failure to grow. She had encountered only the usual diseases of childhood. Appetite was always poor. At the age of 11, the left eye developed an internal deviation deformity necessitating the use of glasses. Dyspnea has been a constant symptom although no difficulty in breathing has been noted at night. No genito-urinary symptoms were noted with the exception of polyuria which was associated with polydypsia. These were always present.

Pregnancy and delivery were considered normal and birth weight was five pounds. "Knots" were noted on the ribs at the age of one month.

*R. D. Age* — 14 *Female* (Figs. in MG percent)

| | | | | |
|---|---|---|---|---|
| (25-35) | NPN | 159 | | 122 |
| (10-15) | Urea N | 138 | | 103 |
| (1-2) | Creatinine | 8.5 | | |
| (9-11) | Calcium (serum) | 5.4 | 5.8 | 6.7 |
| (5.0-5.5) | Phosphorus (inorg.) | | 5.9 | 4.5 |
| (5-15) | Phosphatase (alk.) (Bodansky) | 17.1 | | 22.6 |
| (570-620) | Chlorides (serum) | 652 | | |
| (45-65) | $CO_2$ comb. power | 17 | 22 | |
| | Serum Proteins | | | |
| | (6.5-8.2) Total | 8.4% | | |
| | (4.6-6.7) Alb. | 5.6% | | |
| | (1.2-2.3) Glob. | 2.8% | | |
| | Sulkovitch test | Twice negative | | |
| (0-15) | Sed. Rate | 28 Vol. (packed cells 34 — corrected 24) | | |
| | Gastric acidity | Free acid | 0 | |
| | | Total | 16° | |
| | RBc | 3.37 | | |
| | WBc | 7,450 | | |
| | EKG | normal | | |
| Urine | Acid | Sp. Gravity conc, not over 1.012 | | |
| | Albumen | Negative | | |
| | Sugar | Negative | | |

*Figure 2 The graphs above summarize the laboratory findings pertaining to this patient.*

After the first year, cod liver oil was given in unknown amounts. At one time sugar was said to be present in the urine. We were unable to determine the presence of albuminuria in the past history. Sphincter control had been good.

Examination showed a grossly underdeveloped female, small in stature, with marked bowing of the legs, who walked with much difficulty and effort. No cyanosis was seen although some clubbing of the fingers was apparent. Frontal bossing without local tenderness was noted. The patient wore glasses. The fundi and visual fields were normal. The neck region was not unusual. The breasts showed slight development. The chest was symmetrical with prominence of the costochondral junctions. The heart was not enlarged, but a grade II systolic murmur was present over the entire precordium. Sinus arrhythmia was noted. The abdomen was flat and soft. No masses were made out and the kidneys were not palpated. The genitalia were those of a normal prepubertal female. All reflexes appeared within normal limits. Muscle weakness was generalized and pronounced. Dorsal rounding was prominent on standing. The patient stood with some flexion at each knee although a full range of passive motion was noted in all joints of both lower extremities. (FIGURE 1 & 2)

Roentgenograms of the skull revealed fine granular osteoporosis. The long bones demonstrated widening of the metaphyses and thickening of the epiphyseal lines. Intravenous pyelograms were done and little outlining of the kidneys was noted after thirty minutes with no outlining of the internal caliceal structures of the kidneys.

Roentgenograms of the abdomen 24 hours later revealed the presence of opaque media in the large bowel and appendix, demonstrating the excretory function of the bowel in the absence of kidney function. Small atrophic kid-

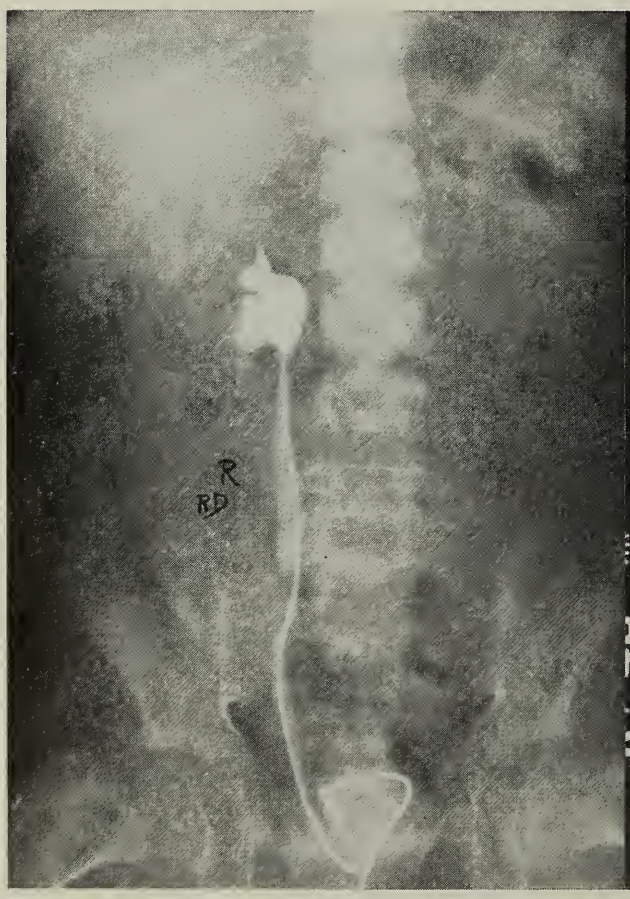



*Figure 3. Retrograde examination of the urinary system failed to demonstrate an obstructive lesion. The left kidney visualized in a similar manner.*

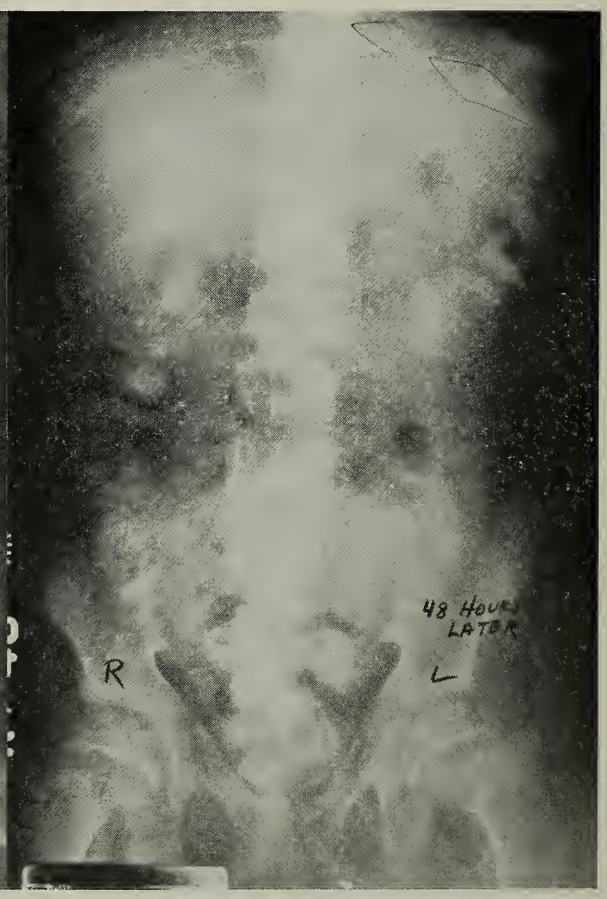



*Figure 4. Antero-posterior view of the abdomen 48 hours after administration of dye for renal visualization. The dye began to appear in the large bowel five hours later. The renal system failed to visualize at any time.*

neys were demonstrated by this study. No obstructive lesions could be found on cystoscopy and no history on renal infection in life could be found. (FIGURES 3, 4)

The patient was discharged from the hospital and died four weeks later.

In summary, renal osteodystrophy is a syndrome with renal and bone changes. No single theory proposed by investigators to date explains the clinical picture entirely. Severe kidney dysfunction is compensated for to some extent by the ability of the bowel to accept some of the excretory power ordinarily carried out by the renal system. The case presented shows dye used to outline kidney shadows in roentgenogram studies to be present in great quantity in the large bowel.


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## The office aide

A well trained, thoughtful hostess — which is one of the primary functions of your office aide — will never let anyone enter your reception room without an early greeting. Having greeted the patient, your aide will give him some idea of the interval of time before he will be able to see you. If there is to be any unusual delay she will explain the situation and let the patient decide whether to wait for you or to use the time elsewhere and arrange a new appointment for another day. Perhaps you have had the experience during a railroad journey of being detained by an equipment breakdown or for some other reason. What is so maddening about such incidents is not the delay in itself but the fact that no one takes the trouble to tell you what has caused it and how long the delay is likely to last. *James E. Bryan. The Doctor and his Office. Pennsylvania M.J. Nov. 1955.*

# Extrapyramidal Symptoms Following Thorazine Medication

**Eli Bader, M.D., Chicago**

When any new drug is introduced, the question always arises about possible toxic effects that may hinder its therapeutic use. When this presentation was first contemplated, the chief toxic effect of Thorazine® seemed to be a form of jaundice due to biliary stasis. Recently, it has become evident that a Parkinson-like syndrome, perhaps better called an extrapyramidal syndrome, has been reported more and more frequently.

At the time the patient to be discussed developed extrapyramidal symptoms, there were only two references in the literature to this type of syndrome following the administration of Thorazine. However, it has been mentioned numerous times by now and it also has made its appearance during the administration of Serpasil®. At present, the mode of action of Thorazine still is a matter of speculation, the most commonly held view being that it affects the hypothalamic-thalamic-cortical pathways in some way and functions, therefore, as a sort of chemical lobotomy. Again, there is no satisfactory explanation of the cause or pathology of the toxic manifestations noted.

The patient, a 32 year old, white female, was brought to the Elgin State Hospital on January 25, 1955, in a highly agitated condition. She had been hospitalized in June of 1951 and again in June of 1953, the diagnosis on the first occasion being paranoid schizophrenia and on the second, schizophrenic reaction, chronic undifferentiated type. She received insulin coma therapy on both occasions and showed what was considered adequate remissions from acute symptomatology.

The present acute illness began approximately one month before admission when the patient showed evidences of change in behavior. Over a period of one month, she became more and more disturbed, finally throwing things about the house, lighting books of matches, and threatening her husband and son.

When the patient entered the Elgin State Hospital, her agitated condition necessitated restraints. She was hyperactive and hypertalkative, although she appeared to be in fairly good contact and was cognizant of the fact that she was in a mental institution. After four days she had shown no response to ordinary sedation and hydrotherapy, and remained extremely hostile and antagonistic.

Thorazine was decided upon because of her hyperactivity and on January 29 she was started on 50 mg. IM., V.i.d. The next day, the patient was willing to take medication by mouth and Thorazine was given in dosage of 100 mg. q.i.d. After three days, she was noticeably quieter and more co-operative. However, her basic psychotic thinking showed no change and she remained hostile.

By February 8, her condition improved sufficiently to enable us to transfer her to a better ward. On the next day, the attendant noticed the patient's walking was rather stiff and by February 10 she was described as appearing rigid as she walked and slobbered. On examination at that time, she showed marked incoordination of movements, adiadochokinesis, and other symptoms suggesting extrapyramidal pathology.

Our neurological consultant noted the following. "This patient is rather remarkable, in so far as on previous hospital admissions there were no neurological findings. Today, they are in abundance, manifested by a rigid posture, moving about en masse, with loss in associative movements, masked facies, infrequent blinking, and pronounced bilateral tremor most marked when excited or disturbed, but present even at rest. The tremor is characteristically that of an extrapyramidal syndrome. There also was pronounced

*Presented before the Physicians' Association of the Department of Public Welfare, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

cogwheel rigidity involving all extremities and the extraocular, head, and neck muscles. Her voice is characteristically monotonous and propulsive. This latter characteristic is true also of her mood, as she nervously paces the floor, seemingly unable to remain seated for any sustained period of time. This is, beyond a doubt, in my estimation, an extrapyramidal syndrome in a person who also seems angry and hostile, but easily calmed down."

Thorazine medication was immediately discontinued and within 48 hours, there was considerable improvement in her extrapyramidal symptoms. When again seen on February 18 by our neurological consultant, all traces of the extrapyramidal syndrome had vanished. It was concluded that the symptomatology the patient showed was due to Thorazine; she had received no other medication.

The patient, although remaining paranoid in her thinking, did not regress to the agitated, extremely hyperactive state present on admission. Actually, from the point of view of her ward adjustment she seemed to show further improvement and was able to participate in ward activities. The patient had served in the WACS and on March 10, at the request of the Veterans Administration, she was transferred to the Downey V.A. Hospital. At that time, although she was considerably improved over her condition on admission, she remained psychotic. At the time of discharge, she showed no evidence of the extrapyramidal symptoms which had been noted following Thorazine medication.

It is interesting to speculate about the pathology that would produce the syndrome noted in this patient. Since within a space of 48 hours, there was a marked improvement in the toxic manifestations, one is tempted to view this as a possible allergic manifestation of the drug, the symptoms resulting from edema which could involve the substantia nigra and basal ganglia or their associated pathways. None of the recent comments in the literature concerning this syndrome indicates that any of the patients who showed these manifestations were left with permanent residuals.

## SUMMARY

1. The case presented in one of an extrapyramidal syndrome following the administration of Thorazine in what is now considered an average dosage. This syndrome appeared after 10 days of medication and subsided rapidly within 48 hours following discontinuation of medication.

2. It is speculated, on the basis of the early appearance of this syndrome and its rapid subsidence following discontinuation of medication, that it may be an allergic phenomenon.
than discontinuation of medication.

3. No treatment seems to be indicated other than discontinuation of medication.

# Stricture of Esophagus Due to Accidental Ingestion of Urine Testing Tablet (Clinitest).

MARVIN I. LASKY, M.D., ROCK ISLAND, AND H. N. PICARD, M.D., ALPHA

STRICTURE of the esophagus is not uncommon following ingestion of a caustic alkali, whether accidental or with suicidal intent. A high number of cicatricial stenoses of the esophagus due to ingestion of caustic alkali has been reported by several observers.[1,2,3]

This paper presents a case of benign stricture of the esophagus which developed after a Clinitest® tablet* was taken by mistake for an aspirin tablet. Ingredients as listed by the manufacturer of this tablet are: copper sulfate, caustic soda, soda bicarbonate, and citric soda. The exact percentage of ingredients is not given. Although this patient realized her mistake and immediately followed antidotal instructions, she eventually developed stricture of the esophagus due to an alkali burn. This occurred in spite of almost immediate treatment by her local physician.

A 64 year old white married woman was admitted to the Moline Public Hospital on Sept. 2, 1954 with a history of six weeks of progressive dysphagia. At the time of admission there was some difficulty in swallowing liquids.

On July 30, 1954 this patient, who is diabetic, swallowed a Clinitest tablet with a small gulp of water, mistaking it for aspirin. She immediately developed substernal pain and frothing of the mouth. Realizing her mistake she drank 3 or 4 ounces of vinegar as directed on the bottle and called her local physician, who admitted her to the hospital, where she stated they pumped her stomach and washed it out with milk. After 3 or 4 hours she was released and went home.

is difficult to evaluate since loose bowl move-

Approximately two weeks later she developed difficulty in swallowing solid food. Dysphagia became progressively worse until, at the time of admission, there was difficulty in swallowing liquids.

This woman, who had made an uneventful recovery from a cholecystectomy the previous year, never had any difficulty previously in swallowing or phonation.

Physical examination at the time of admission revealed early diabetic retinal changes but no other physical impairment. The patient was thin but in a fairly good nutritional state. Her swallowing difficulty had not become acute until a short time prior to admission. X-rays and barium study of the esophagus revealed a constricting lesion of the esophagus with a questionable ulcer crater at the level of the aortic arch. Figure 1. Esophagoscopy by one of us (M.I.L.) revealed a cicatricial stricture of the esophagus about 21 cm. from the upper incisor teeth. No ulceration was noted and the lumen was reduced to a diameter of about 6 mm.

Following esophagoscopy, repeated dilatation of the esophagus was performed with metal bougies over a previously swallowed silk thread. This patient has now made a complete functional recovery and has no dysphagia. At present, she is being observed periodically in the office.

## COMMENT

Although these urine testing tablets are clearly labeled POISON and NOT TO BE TAKEN INTERNALLY, patients must be instructed as to their proper use. Because they contain caustic soda these tablets should be and are conspicuously labeled POISON as required by the Federal Caustic Act of 1927. When these tablets come into contact with mucous membrane they

*From the Moline Public Hospital, Moline*

*Clinitest — Mfg. by Ames Co., Inc., Elkhart, Ind.

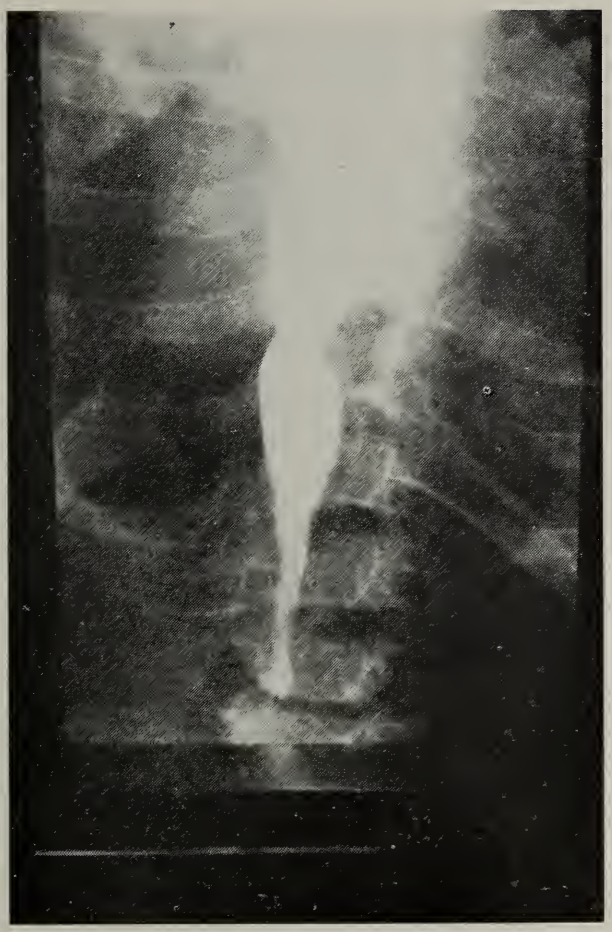


Figure 1

have an affinity for water and destroy moist tissue rapidly. An intense heat of reaction is liberated which can cause deep burns of mucous membrane and superficial burns of the skin.

In the above case, the patient sustained a not insignificant burn of the esophagus even though first aid measures were instituted immediately. It is assumed that either the ingested tablet stuck to the wall of the esophagus due to the chemical reaction and that the swallowed vinegar went right on past or that the burn was caused within the short time interval before the patient swallowed the vinegar. Although we have heard of no ophthalmic burns caused by particles of this type of tablet entering the eye it is conceivable that this might cause a severe corneal or conjunctival burn.

412 Cleveland Bldg.

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## How many drug stores?

On January 1, 1955, there were 51,690 retail pharmacies in the entire United States. This number, which does not include hospital pharmacies, is 233 less than the number on January 1, 1954; approximately the same as the number on January 1, 1953; and approximately 1,000 more than the number on January 1, 1951. The data relating to the number of hospital pharmacies were incomplete but indicative that the total number in the U. S. is in excess of 2,000. The number of registered pharmacists engaged in the pharmaceutical profession and industry in the United States increased from 105,590 on January 1, 1954 to 108,990 on January 1, 1955; a gain of 3,400 of the total number of whom 95,993 were engaged in retail pharmacies, a gain of over 1,200. *National Assn. Boards of Pharmacy 10:11, 1955.*

# EDITORIALS

## Prophylaxis of atherosclerosis

Experimental studies on atherosclerosis continue to support the dietary pathogenesis of this disorder. According to Katz[1] it is possible to produce atherosclerosis and hypercholesterolemia consistently in the majority of laboratory animals through dietary measures that alter cholesterol-lipid-lipoprotein metabolism.

We now have more conclusive laboratory evidence that estrogens also play a role in atherogenesis to explain why premenopausal women are relatively immune to coronary disease.

The Michael Reese Hospital studies show that atherosclerosis of the aorta and the coronary arteries can be induced readily in chicks by feeding a cholesterol-lipid supplemented atherogenic diet. When estrogens (any active type) were given parenterally or orally to cholesterol fed cockerels, plasma lipids were reduced. Coronary atherosclerosis was prevented but aortic lesions were not influenced by the hormones.

Feminization occurred. It was controlled in later experiments by using a combination of estrogens and androgens in a 3:1 ratio without affecting the typical estrogen effects on the lipids and coronary vessels. When the cockerels were fed cholesterol for eight weeks and then given estrogens in addition to the atherogenic diet for five weeks, there were no coronary lesions. This demonstrates that atherosclerosis, once established, can be reversed.

Cholesterol fed egg producing hens behaved like cholesterol fed cockerels that received estrogens. They were immune to coronary but not to aortic atherosclerosis. They were not losing cholesterol in the eggs because, when the oviducts were ligated, the situation remained unchanged. On the other hand, the mature cholesterol fed roosters developed extensive lesions of the coronary arteries and aorta. These findings were in marked contrast to those in immature and castrated male birds.

The sex difference in susceptibility to coronary atherogenesis in mature chickens parallels that observed in humans. By including a combination of hormones in the low fat-low caloric diet initiated by Gofman, we may have an improved way to prevent recurrences of myocardial infarction and prolong the life of males under 50 who are recovering from a proved coronary occlusion.

[1]Katz, Louis N. The Role of Diet and Hormones in the Prevention of Myocardial Infarction. Ann. Int. Med. 43:930 (Nov.) 1955.

## Drs. Julius H. Hess, Isaac A. Abt, world renowned pediatricians die.

Within a period of three weeks recently, the Illinois State Medical Society lost two long-standing members and world renowned pediatricians, both Chicagoans.

Dr. Julius H. Hess, 79, died suddenly of a heart attack November 2, 1955, while vacationing in Los Angeles. Dr. Isaac Arthur Abt, 87, died November 22, 1955, in his home. Both had made outstanding contributions to the knowledge of children's diseases, their cause and treatment. Both had been recognized by their medical colleagues with awards for these services to humanity.

Born in Ottawa, Illinois, January 26, 1876, and a graduate of the Northwestern University Medical School in 1899, Dr. Hess was professor and head of the department of pediatrics at the University of Illinois for 30 years before his retirement in 1944, when he was named professor emeritus of pediatrics.

Much of his medical career was tied in with the Michael Reese Hospital, where he was senior attending physician and past staff chairman. He was instrumental in establishing the first premature station at the Sarah Morris Hospital, a unit of Michael Reese. Among his contributions in that field were the devising of a small hand ambulance bag to facilitate the transportation of premature infants, an electrically heated water jacketed bed, and an oxygen therapy unit for premature infants.

Dr. Hess was president of the Chicago Medical Society in 1934-35 and later vice-president of the Institute of Medicine of Chicago. He served as an Illinois State Medical Society's representative in the American Medical Association's House of Delegates in 1951 and also at one time was chairman of the AMA Section on Pediatrics.

He was certified as a specialist by the American Board of Pediatrics, a Fellow of the American College of Physicians and a member of the American Pediatrics Society and American Academy of Pediatrics. The latter group in 1952 presented him with the Borden Award "for his many productive contributions to the care and management of the prematurely born infant."

Dr. Hess was appointed to the Medical Advisory Committee of the Illinois Emergency Relief Commission on its formation 23 years ago and served similarly on that organization's successor, the Illinois Public Aid Commission.

He was identified with many public welfare activities, including the advisory board, Children's Bureau, U. S. Department of Labor; Illinois Board of Welfare Commisioners; advisory board of Prevention of Juvenile Delinquency: Cook County and Chicago Welfare Administration, and executive board of the Municipal Contagious Disease Hospital. He was chairman of the medical committee of the Jewish Children's Bureau.

In World War I, Dr. Hess served overseas as a major in command of General Hospital No. 25. During World War II, he was a member of the Illinois Defense Council on Youth and Welfare which developed programs to prevent juvenile delinquency.

He contributed many chapters to systems of pediatrics and was the author of "Feeding and Nutritional Disorders of Infancy and Childhood," "Premature and Congenitally Diseased Infants," and "The Physical and Mental Development of Prematurely Born Children." He also was co-author with Dr. Evelyn C. Ludeen of "The Premature Infant."

Dr. Abt was born December 18, 1867, in Wilmington, Illinois. He was graduated in 1891 from the Chicago Medical College, then the medical department of Northwestern University. At his death, he was retired from active practice but was consultant for Michael Reese Hospital, Children's Memorial Hospital and other organizations, and emeritus professor of diseases of children, Northwestern University Medical School.

When he began medical practice, there was no such branch as pediatrics. Children accounted for two-thirds of the deaths in Chicago, and infants had only a 50-50 chance to life beyond the age of 5.

This situation was a challenge to Dr. Abt. He decided to pioneer in pediatrics and in time gained world fame. Nevertheless, he always referred to himself as a "baby doctor" rather than a pediatrician.

He administered the first diphtheria antitoxin in Chicago at a time when that disease often wiped out an entire family. This he did in the face of bitter opposition to antitoxins in many quarters.

He recognized and treated the first case of infantile scurvy, and pioneered in the battle for a safe water supply and the pasteurization of milk. He was one of the founders of the Infant Welfare Society.

In 1909, Edward Morris offered him a children's hospital, now the Sarah Morris Hospital, a part of Michael Reese. Pediatrics was constantly raised to a higher level under his insistence. He contributed to knowledge in that field by editing the Yearbook of Pediatrics for nearly 40 years.

His outstanding literary work was his "System of Pediatrics," composed of eight volumes, written in collaboration with American specialists. This enabled physicans throughout the world to

have access to the best teachings on child care.

In 1948, Dr. Abt received the AMA's Distinguished Service Award "for notable contributions to the literature of his specialty."

Besides the Illinois State Medical Society, Chicago Medical Society and AMA, he was a member of Institute of Medicine of Chicago, Chicago Pediatric Society, Society of Medical History of Chicago, American Pediatric Society and American Academy of Pediatrics. He was certified as a specialist by the American Board of Pediatrics.

Both Dr. Hess and Dr. Abt were honored during their lifetimes by the medical profession, but living monuments to them are the untold number of people who are alive today because of the contribution of these physicians to world-wide medical knowledge. There can be no greater memorial.

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## Rep. Van der Vries, champion of public health, to retire

Rep. Bernice T. Van der Vries (R. Winnetka) recently announced her retirement from public life after having served as representative in the Legislature since 1934. Mrs. Van der Vries throughout her legislative career has been a staunch supporter of every effort for improvement of the health and welfare of the people of Illinois and for good government. She has consistantly backed measures approved by the Illinois State Medical Society.

Her decision to retire brought well deserved editorial praise of her services by the Chicago *Tribune* and Chicago Daily *News*. Both agreed that she is entitled to rest, but they also agreed that it will be a loss to the state.

"The state will be better served if she can be prevailed upon to reconsider her decision," said the Chicago *Tribune*.

It pointed out that if her decision stands it "will most certainly lower the quality of Cook County's representation in the Legislature." The *Tribune* added that "if she does retire, the new North Shore district will have no spokesman with legislative experience in either the House or Senate."

The Daily *News* said Mrs. Van der Vries "has been one of the most competent and gifted members of the Illinois General Assembly ever since she was first elected to her post in 1934," and expressed the hope that "her successor will give as much of unselfish devotion to the public interest as has Mrs. Van der Vries."

Last November, the Illinois Interprofessional Council — of which the Illinois State Medical Society is a member — presented her the first of what is to be an annual "Distinguished Citizen Award" for service in the interest of public health and welfare.

The Illinois State Medical Society joins in the praise for Mrs. Van der Vries and agrees she is entitled to a rest from her arduous labors. However, the Society also hopes that she will be prevailed upon to change her mind.

That is a woman's prerogative. In this case, a change would be an assurance that the people of Illinois will continue to have a great champion in the Legistlature.

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## Polio ahead: the reasons behind the 1956 Illinois March of Dimes

The Salk vaccine is a major weapon against paralytic poliomyelitis, but it has not yet won the war against this disease.

Illinois will still have polio problems in 1956 despite the conscientious efforts of private physicians, public health officers and the National Foundation for Infantile Paralysis to bring the disease promptly under control.

The following brief review of what the National Foundation, supported wholly by its January March of Dimes, has already done to help meet polio problems in the state of Illinois gives an idea of the tasks that still lie ahead. Since 1938, when the National Foundation was organized, these things have been accomplished:

Over $12,800,000 has been spent by local chapters in Illinois for the care of polio patients. (There are 102 chapters in the state).

A total of 262 National Foundation scholarships and fellowships has been awarded to Illinois residents.

Professional education grants in addition to Illinois institutions have totaled $125,000.

A considerable amount of research in virology and the treatment and after-care of poliomyelitis has been conducted in Illinois. Toward this research the March of Dimes has contributed $750,000.

Illinois institutions currently having March

of Dimes grants are the Evanston Hospital, Illinois Children's Hospital, University of Chicago and the University of Illinois. Among previous grant recipients, in addition, were: the Chicago Board of Health, Loyola University, Illinois Committee on Infantile Paralysis, Michael Reese Foundation. Northwestern University, Passavant Memorial Hospital and St. Johns Hospital (Springfield).

Emergency aid in dollars and in equipment for polio patients has been generously supplied. In the first 10 months of 1955 a total of $82,-926.10 in emergency aid was sent to 12 Illinois chapters by the national headquarters of the National Foundation. In the year 1954 the amount was $323,325 to 48 chapters.

A total of 17 tank respirators, 16 chest respirators and 39 rocking beds were sent into Illinois as emergency shipments in the first 10 months of 1955. The previous year Illinois got 92 respirators and 53 rocking beds.

Finally, 719,000 cc. of Salk vaccine were given to the state of Illinois without charge by the National Foundation to initiate its statewide vaccination program in 1955.

We are at the point now where continuing co-operation of physicians must be had both in administering the vaccine and in caring for patients already paralyzed and *who will be* paralyzed in spite of the vaccine. The Salk vaccine is not 100% effective and it will take considerable time yet, perhaps years, before all individuals most susceptible to paralytic poliomyelitis can be fully immunized against it.

The results already reported from the use of the vaccine are most encouraging but they must not be allowed to blind the eye of the medical profession to the road that still lies ahead. There remains a great need for additional research to improve the Salk vaccine, to determine the duration of immunity it effects (and conversely to determine the need for "booster shots") and to provide the best possible treatment for patients already or yet to be involved with paralytic poliomyelitis. There is also a vast need for the professional education of young men and women who will contribute to the necessary research and help give the needed treatment.

To pay for research, education and aid to polio patients, the March of Dimes needs $47,-600,000 in 1956. Illinois physicians, knowing both the need and the record, will want to support and urge their patients to support the 1956 March of Dimes in their own communities.

Hart E. Van Riper, M.D.

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## The A.M.A. clinical session in Boston

The 1955 Clinical Session of the American Medical Association was held at Boston on November 28-December 2, and as usual, Illinois was well represented at this session. The House of Delegates had two very busy sessions lasting most of the two full days. Four Illinois delegates were on reference committees, and another was one of the sergeants at arms. There was much discussion of the H.R. 7225 bill relative to social security.

It was the desire of the House of Delegates to have the A.M.A. pledge its wholehearted co-operation in an effort to get a full evaluation of the Social Security Act, as it had been reported that during the current session of the Congress, no less than 247 bills had been introduced to make various changes in the Act.

The A.M.A. Committee to Recommend Guides for Grievance or Mediation Committees gave an interesting report. It seemed desirable to promote general uniformity of organizations and functions of grievance committees. The reference committee in its report recommended that a brochure be published promptly to give information to the Grievance or Mediation Committees of the respective State and Territorial Societies.

The subject of medical ethics was given a great deal of consideration by the House of Delegates. A proposed revision of the Principles of Medical Ethics and Precepts of Manners of the American Medical Association, was submitted to the House of Delegates by the Council on Constitution and Bylaws. Copies of the proposed revision were available for the members, and it was deemed advisable to get these proposed changes to the entire membership of the A.M.A. It was also deemed advisable for the Council on Constitution and Bylaws and the Judicial Council to meet jointly to consider these proposed changes, so they may be acted upon at the next Annual Meeting in June, 1956.

Another action taken on revisions of medical

ethics, was one approving a plan requiring that all resolutions dealing with changes in the Principles of Medical Ethics shall be considered over a period between sessions of the House before final action can be taken.

The House by unanimous action, approved a resolution introduced by the Illinois delegation, also sponsored by the state societies of Wisconsin, Louisiana, and Colorado, congratulating the Iowa State Medical Society for its efforts in supporting the position that the practice of medicine is the right of the individual.

The membership attendance at the Boston meeting was about 3,750 and the total attendance approximately 10,000. The House of Delegates voted to hold the 1960 Annual Meeting in Chicago, and the 1958 Clinical Session in Minneapolis.

The transactions of the House of Delegates will be published in early issues of the Journal of the A.M.A. and we would urge every member to read these transactions carefully to learn what your delegates have done for the welfare of the public as well as for the best interests of the profession as a whole.

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## Medicine on postage stamps

Among the many hobbies of members of the medical profession, the collection of stamps is well at the top of the list. We often wonder how many philatelists in the profession realize how often medicine is referred to on postage stamps. We are mentioning some of these references as seen in 1955 issues.

Algeria — A 15-franc stamp showing Aesculapius, god of healing in Greek mythology, and El Kattar Hospital, to publicize the French Congress of Medicine.

Ethiopia — Three stamps showing Princess Tsahai, in nurse's uniform at a sick bed; issued to commemorate the 20th anniversary of the founding of the Ethiopian Red Cross.

Finland — Three semi-postal stamps with fish designs and the Lorraine Cross, surtax going to the Anti-Tuberculosis Society.

India — A 6-annas stamp inscribed "malaria control," showing a cadusceus.

Italy — A 25-lire stamp picturing Battista Grassi (1854-1925), who contributed to understanding of malaria by studies of life processes of mosquitoes.

Monaco — Four stamps in honor of Dr. Albert Schweitzer, medical missionary.

Saar — 15-franc semi-postal, showing nurse holding baby.

Turkey — A 20-k stamp showing a battle field first aid station, 30-k showing military hospital at Ankara, both issued to commemorate the International Congress of Military Medicine; three postal tax stamps showing nurses, issued in connection with the meeting of the International Council of Nurses, and three other postal tax stamps showing nurse holding child.

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## Medical education 100 years ago

The following letter was written to his parents on November 5, 1859, by an uncle of Dr. John Q. Roane of Carlyle, Illinois, to whom I am indebted for the copy. The writer was just entering the Medical School at Keokuk, Iowa, and gives us an excellent picture of the school, and the state of medical education at that time. Notice that some of the students had been practicing for years (probably without previous medical training) and were as ignorant as quacks. Young student Roane also stated that in his opinion no one should attempt to practice medicine without attending at least one course of lectures, which usually lasted sixteen weeks at that time. To his credit it may be said that he attended two courses before returning to Mt. Vernon, Illinois, to practice.

Keokuk, Iowa
Nov. 5, 1859

Mr. & Mrs. Edward Grant

Mt. Vernon, Illinois

Dear Uncle & Aunt:

I thought when I left your house that I would write to you as soon as I arrived in Keokuk, but a multiplicity of occurrences have so conspired to defer the time till this pleasant Saturday evening.

I arrived here Thursday morning after leaving your house and had a pleasant trip. I only paid three dollars fare from St. Louis to this place, a distance of 225 miles or 230, the cheapest traveling I have ever done. The weather has been remarkably fine ever since starting and so

mild for the last two days that we have not kept fire in the room.

Keokuk is a pleasant healthy place of about ten or twelve thousand inhabitants. It is thought that it has lost about one-third of its population in three years, having suffered worse in the late panic than any other city in the west. Some few residences and many business houses are vacant and many buildings were abandoned.

I am boarding at three dollars per week and agreeably situated with one roommate. There are about 70 students in attendance and they are still coming in. It is a fine place to get instruction and the faculty take a great deal of interest in their students. I felt very green in entering but I find most of the students are as bad or worse. Some of them have been practicing for years and are as ignorant as quacks can well be. I have just seen the operation for lithotomy, stone in the bladder, performed on a little child of four years old. The stone extracted was much larger than a partridge egg. I never want to see another such operation performed.

I will be very busy from this time forward, having to attend six lectures daily and read up during intervals.

Besides we will have to dissect at night as soon as the weather gets cool enough! This is a sort of holiday this evening and most of the boys are out enjoying themselves but I have several letters to write notwithstanding the weather is so fine and I find myself as well posted as most of them. I do enjoy myself here and long to see the time arrive to leave, though *I do believe anybody is a fool to undertake to practice medicine without attending at least one course of lectures.* I will not have much time to write hereafter. You must all write to me and let me hear what is going on. I hope to see you all in the spring. Adieu for the present.

T. T. Roane

The second volume of the History of Medical Practice In Illinois records the rapid changes which took place in medical practice between the period described in this letter and 1900. Our recent progress has been spectacular but we must not forget that most of the groundwork which made our recent discoveries possible was done in the half century described in Volume II.

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## Let's have your name, Doctor

The revision of the List of Speakers is now under way by the Scientific Service Committee of the Illinois State Medical Society. In response to notices that have appeared in various publications, some 150 physicians have submitted their names together with their preferred subjects.

The Scientific Service Committee believes professional modesty is responsible for the poor response. This is regretful because the Committee would like to have all physicians available to help it render assistance to the county medical societies throughout the state.

How about it, Doctor? Are you available? You do not need to be identified with a teaching position on a university staff, nor is it necessary that you have many years of practice behind you. Do you know your subject and can you present it in clear and interesting language?

The Scientific Service Committee is your committee, Doctor. You help maintain it. Why not help it to function in its responsibility of assisting program chairmen and secretaries of county medical societies in arranging their programs?

Send your name and subjects together with a brief "pedigree" to Louis R. Limarzi, M.D., Chairman of the Scientific Service Committee, 185 North Wabash Avenue, Chicago 1, Illinois, Suite 1909.

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# MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

# Blue Shield and Blue Cross Changes

**Frederick W. Slobe, M.D., Chicago**

THE PERIOD between November 1, 1955, and the early part of 1956 constitutes another important milestone in the development of both Blue Shield and Blue Cross in Illinois. Some of these changes became effective November 1, and others will occur from one to four months thereafter. Physicians will be interested in learning the essentials of these improvements because of the many inquiries they receive from their patients.

## BLUE SHIELD

*The General Blue Shield Certificate.*—This certificate is now held by over 1,250,000 people in Illinois. There are no changes in benefits at this time, although numerous liberalizations have been added in the past without any increase in the dues paid by the members.

This certificate will be available, as always to groups and probably, some time in 1956, also to individuals who qualify as non-group members at that time.

*The Series "C" Blue Shield Certificate.*—A new Blue Shield Certificate, the Series "C" Certificate, became available and effective about December 1, 1955. This will be offered to certain groups who desire a higher schedule of payments to physicians and are willing, of course, to pay the increased dues. When the next Physicians' Handbook is issued, it will contain allowances for the Series "C" Certificate in a separate column adjacent to the allowances applicable in the General Certificate.

Coverage for office surgery, which is confined to 16 specified procedures in the General Certificate, is changed to include all operations performed in the doctor's office, clinic, or patient's home.

The following table shows the comparison between various representative allowances:

| *Surgery* | "General" Certificate | Series "C" Certificate |
|---|---|---|
| Range in allowances | $ 5.00 to $200.00 | $ 5.00 to $375.00 |
| Maximum total in 90 day period | 200.00 | 400.00 |
| Individual allowances | | |
| Appendectomy | 100.00 | 150.00 |
| Brain tumor, excision of | 200.00 | 375.00 |
| Breast tumor, benign, excision of | 35.00 | 50.00 |
| Cataract, extraction | 125.00 | 200.00 |
| Cholecystectomy | 125.00 | 225.00 |
| Cyst, sebaceous, excision of | 10.00 | 15.00 |
| Dilation and curettage of uterus | 25.00 | 40.00 |

*Medical Director, Blue Shield Plan of Illinois Medical Service and Blue Cross Plan for Hospital Care.*

| | | |
|---|---|---|
| Hemorrhoidectomy | 50.00 | 75.00 |
| Hernia, inguinal, unilateral | 75.00 | 125.00 |
| Hysterectomy | 125.00 | 225.00 |
| Mastectomy, radical | 125.00 | 225.00 |
| Prostatectomy | 125.00 | 225.00 |
| Pulmonary-aortic anastomosis | 200.00 | 375.00 |
| Tonsillectomy | 35.00 | 50.00 |
| Surgery in office, clinic, home, or hospital outpatient department | 16 specified procedures | All |
| *Obstetrical* | | |
| Delivery (excluding prenatal care) | 60.00 | 85.00 |
| Cesarean section | 100.00 | 150.00 |
| *Medical* (Hospital inpatients) | | |
| Waiting period | 2 days — retroactive to 1st day for stays of over 2 days | Same |
| First 5 daily visits | 5.00 each | 10.00 each |
| Next 65 daily visits | 3.00 each | 4.00 each |
| Electric shock treatments | 10.00 each | 10.00 each |
| Maximum per calendar year | 50.00 | 80.00 |
| Insulin shock treatments | 3.00 each | 3.00 each |
| Maximum per calendar year | 50.00 | 75.00 |
| Diagnostic skin tests | | |
| Scratch (maximum per calendar year) | 15.00 | 25.00 |
| Scratch and intradermal (maximum per calendar year) | 25.00 | 40.00 |
| *Radiology* | | |
| Diagnostic | | |
| Skull, multiple views | 15.00 | 20.00 |
| G.I. series and gallbladder | 15.00 | 25.00 |
| Humerus shaft | 5.00 | 7.50 |
| Finger | 5.00 | 5.00 |
| Maximum per 90 day period (per schedule) | 15.00 | 25.00 |
| Radiation therapy | | |
| Maximum per calendar year, superficial | 50.00 | 50.00 |
| deep | 150.00 | 200.00 |
| X-ray therapy (each) | 10.00 | 10.00 |
| Radium therapy | Individual Consideration | 10-60 |
| *Anesthesiology* | | |
| For appendectomy | $ 15.00 | $ 20.00 |
| For brain tumor | 35.00 | 47.50 |
| For cholecystectomy | 20.00 | 30.00 |
| For hysterectomy | 20.00 | 30.00 |
| For pulmonary-aortic anastomosis | 35.00 | 47.50 |
| For delivery | 15.00 | 17.50 |
| *Pathology* | | |
| Maximum per 90 day period (per schedule) | 15.00 | 25.00 |
| *Emergency accident care in a hospital within 24 hours of an accident* | | |
| For care for which no scheduled allowance is available | 5.00 | 10.00 |

*Blue Shield Philosophy.*—The basic tenet of Blue Shield remains the same in both certificates. Namely, that the allowances neither fix nor relate to the value of the physician's services. It follows that a Blue Shield payment cannot have any necessary relationship to the value of any one physician's service in any one case. The physician is assumed to make his regular charge and any balance due is payable by the patient. It should be noted, also, that both certificates state that Blue Shield will pay the doctor's charges but not to exceed the amounts listed in the indemnity schedule in the certificate. For items not scheduled, the Plan reserves the right to establish the amount on a comparable basis with operations or services which are listed.

The Blue Shield schedule of allowances does not constitute a fee schedule. The certificate states that this is a "schedule of maximum indemnities," which means that the allowances are payments made to a physician to apply toward his fee. This means that the Plan will pay the physician his charges, but not to exceed the amounts listed in the schedule. So the payments are in the nature of reimbursements, *a very important point being that the money is paid to the physician* instead of to the paient. Obviously, the amount paid toward a certain procedure or service must be influenced by the premium paid and actuarial studies of the incidence of the procedure.

When a patient in a hospital belongs to Blue Shield and Blue Cross, he is not a charity patient since the Plans will make payments to the hospital and physician, respectively. In such a case, the physician does not handle the case as though the patient had no income, but would establish a charge based on the fact that the physician is charging his regular fee, taking into consideration the financial category in which his patient belongs.

## BLUE CROSS

*Benefit period increased.*—In both the Comprehensive and Cooperative Certificates the benefit period has been increased to 120 days per illness or accident. When not separated by a 90 day interval, successive hospital admissions for the same or related condition will be considered as a single continuous hospital stay. This is for the purpose of counting the total number of days used.

Furthermore, if a 90 day interval does elapse between discharge from and readmission to a hospital, the full 120 days are again available even for the same or related condition. If the readmission is for an unrelated condition 120 additional days become available immediately upon any readmission.

*Out of area benefits.*—When admitted to a hospital which is a member hospital of another Blue Cross Plan, or to a recognized hospital located in an area not served by a Blue Cross Plan, the member is entitled to the same inpatient and outpatient benefits as provided in a member hospital.

This means uniform benefits in any of the 6,000 Blue Cross hospitals in the United States and Canada and in recognized hospitals anywhere in the world where there is no Blue Cross Plan.

*Deductible Certificate.*—Blue Cross will soon offer its first deductible certificate for certain groups desiring this sort of coverage. Under this plan the member pays the first $40 of hospital services which are Blue Cross benefits. This applies to each and every admission. This affords, of course, a substantial reduction in the membership dues.

## EXTENDED BENEFITS

In answer to a growing public demand for greater protection in cases of catastrophic illnesses and accidents calling for very long periods of hospital and medical care, both Blue Shield and Blue Cross are making an extended benefits program available by means of endorsements to the basic certificates for a small added premium.

This means that after a hospitalized Blue Shield member has received allowances toward 70 medical (nonsurgical) visits or has been in the hospital 70 days for surgical or obstetrical care he becomes eligible for extended benefits for a total period of 730 days additionally.

During this 730 day period payments are made to apply toward not over four visits a week. If a patient leaves the hospital and is then readmitted within 90 days for the same or related condition, it is considered as a continuous stay. Otherwise the extended benefits cease and the basic certificate becomes operative again at the time of the next admission.

In addition, following discharge from the hospital, payments are made to apply to not more than four home or office visits per week for a period of 90 days upon discharge from the hospital.

As regards Blue Cross, after 120 days of hospital service, the member will be entitled to an additional 730 days of hospital service. Again, if readmission is within 90 days and is for the same or a related condition, the days are counted as one continuous stay. Otherwise the extended benefits cease at the time of discharge from the hospital.

# THE P. R. PAGE



**A "neighborly" PR program for 1956**

Key your 1956 public relations programs to a spirit of neighborliness. Augment the usual mass media approaches by a more intimate mode of communication — personal chats with neighbors and other nonmedical friends, participation in community activities, working with other groups.

This was the advice given by Dr. Dwight H. Murray, president-elect of the American Medical Association at the Eighth National Medical Public Relations Conference in Boston, November 28.

"People like to ask questions and they want immediate answers," Dr. Murray pointed out. "They can't talk to a pamphlet or a magazine. They can't interrupt a radio or television program. And quite frequently when we set up public meetings, at which we invite questions from the audience, the question period is so short that the moderator closes the meeting before most of those in the audience have had an opportunity to get over their initial stage fright."

He stressed the importance of doctors participating in community activities because whatever political battles the medical profession may have won in the past the victories were achieved only through the support of millions of other voters.

"We talk much about how good medical public relations begins in each doctor's office," he said. "Unfortunately, that's where most of it also ends. Outside of his office, many a doctor shields himself from contact with other citizens like a cloistered nun. He uses his wife and children as a buffer between himself and his neighbors.

"Join the P.T.A.? Sorry, too busy . . . Serve as an official of the local Boy Scout troop? My boy is a member, but I haven't much time to help out. . . . How about acting as health officer of the Boy's Club? I'd like to, but . . . . Lions Club? Rotary? Kiwanis? Elks? Chamber of Commerce? Yes, I'm a member and I will try to get to the next meeting, but you know how it is.

"Is it any wonder, then, that we get the feeling so often that nobody understands us and our problems? How can they? We never give other people a chance to know us. Do we understand our neighbors and the rest of the citizens of our respective communities? Hardly.

"We know their appendices, their kidneys, their livers and their tonsils, but we don't know what makes them tick as fellow human beings who live, eat, work and play as we do. If we would but stop and look around we would learn that we have many things in common with our neighbors and they would be very willing to help us with our problems if we would help them with theirs."

This neighborly approach will be most important in 1956, a presidential year. In the months ahead, political candidates will make all kinds of promises. Many will affect the medical profession. Some of the proposals will be supported by physicians. Others will be opposed vigorously because of their socialistic nature and their

threat to the health welfare of the nation. In either event, the backing of the public will be needed.

The medical profession will have to seek out other groups with whom we can communicate intelligently. As Dr. Murray says: "No one is going to give one hoot in hades about the problems of the medical profession if we sit on our pedestals waiting for others to come to us."

The task is no easy one. It will take individual and collective efforts.

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**Apathy is merely adaptation**

The average American citizen shows apathy to dangers which are recurring. Why? A University of Cincinnati psychologist has come up with this answer — adaptation, the protective reaction of an organism (in this case, man) against overstimulation.

It seems that persons constantly subjected to certain highly emotional situations will adapt themselves so as to become impervious to what might develop into painful situations.

Just that has been happening in this country. Apathy on the part of the citizens has allowed a creeping socialism. Unless the population is aroused, this country will be plunged deeper and deeper into governmental control of human endeavor.

The medical profession must guard against the development of this adaptation on a wider scale 'lest the results be disastrous to both medicine and the public.

The year ahead will be a test for doctors. Will they be able to arouse the people of this country to the dangers which confront them, or has apathy grown to a stage that nothing will prevent full-fledged socialism?

Medical societies and women's auxiliaries must be prepared to work harder than ever. Now is the time to set up PR programs which will function with vigor. Only in that way can medicine hope to escape regimentation and prevent deterioration of medical care.

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**Some views on doctors' PR role**

"Public relations is ours individually, for every patient that we see is part of our public relations. A public better informed regarding the cost of the medical procedure with which it is involved would be a great help."—Dr. Robert T. Porter, president of Colorado State Medical Society.

"Our basic strength depends on the individual doctor's relations with individual patients. Good public relations cannot be purchased, nor will lavish expenditure in advertising be much help."—Dr. Walter U. Kennedy, president of the Indiana State Medical Association.

"The root of all physicians' bad public relations rests squarely on the individual M.D. In this connection, it should be noted that the doctor is all too often missing from committees of the Chamber of Commerce and other civic bodies. Doctors should remember that they have duties as *citizens* and that their community needs the help and guidance that physicians are so well equipped by education and training to give."—Dr. Charles L. Farrell, president-elect of Rhode Island Medical Society.

"I judge the medical profession by my doctor. When I go to him, I want to go as a person in whom he is interested rather than as a name on a filing card. I need his interest, his sympathy as much as I do his medical skill."—A columnist in Kansas City Star.

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**Why social security for doctors?**

Are the majority of doctors justified in their opposition to being included under Social Security? A survey conducted by the Schering Corporation provides an affirmative answer. For most physicians, coverage merely will mean an added tax with no benefits.

Answers to a questionnaire sent to doctors 65 years of age — when Social Security would be applicable — reveals:

(1) Four out of five doctors are still in active practice; (2) one out of every two sees more than 40 patients in an average week; (3) one out of every four treats patients of all ages; one out of every two chiefly sees patients between 40 and 60, and (4) one out of every four will handle all types of cases; three out of every four do not accept surgical cases.

In other words, doctors as a rule don't retire at 65 and therefore they can get no benefits from Social Security.

That is one of the thoughts behind the pending Jenkins-Keogh bills, which would correct the inequities that have arisen between employed and self-employed persons. The bills would per-

mit self-employed persons to set aside a limited sum of money for retirement purposes and to defer the income for tax purposes until it is withdrawn.

Every PR program should provide for arousing legislative and public opinion in favor of the bills.

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## Health Insurance

One of the criticisms offered with regard to Blue Cross is that "all risks are charged the same rate, while insurance companies try to classify risks so that each class pays only for its own insurance." This principle is illustrated by life insurance companies where the premium charged depends upon the applicant's age and state of health, or by fire insurance companies where the premium varies with the hazard . . . The most recent health insurance offered by more than 75 companies is known as "catastrophe" or "major medical expense" coverage. It is designed to help you finance the prolonged illnesses or accidents which cost hundreds of dollars. It is considered by insurance men a more logical form of protection and it may be the most desirable pattern for our use in the future. In its framework, it recognizes fundamental insurance principles: that the loss insured against should be of financial consequence and that the loss insured against should be of infrequent occurrence. This latter principle assumes that the ordinary normal medical expense should be absorbed in the budget. Ordinary health insurance does not recognize the above cited principles; consequently, the administrative cost of handling small claims is relatively heavy, and also does not help adequately in paying the large, staggering sums incurred in prolonged illnesses.

Primarily, major medical coverage has a deductible clause similar to that found in automobile policies. If the policy is a $50 deductible, this amount is paid by the insured, and the insurance company pays the remainder of the bill. This feature eliminates the small claims which are quite numerous and which cost so much in overhead. The idea in catastrophe insurance is applied to eliminate the smaller bills which a family budget is capable of including in its ordinary budget. The deductible in this form of insurance usually is set at $100, $200, or even $500 so that protection can be concentrated on illnesses or accidents that are inordinately expensive. Above the deductible, the insurance company pays the combined hospital, medical, surgical, nursing, and other auxiliary expenses. If the insured so elects, the maximum limits in these policies may be as high as $10,000.

Another feature that frequently is offered in this type of policy is co-insurance, which is an elective common in fire insurance underwriting — the payment of 75 to 80 per cent of the total expense above the deductible amount. The remainder of 20 to 25 per cent is paid by the insured. If this feature is included in the policy, it will not only lower the premium rate, but the insured will endeavor to keep expenses down to a reasonable level.

This newer form of insurance has become extremely popular. A recent survey has shown that more than two million people are so protected, a gain of more than 83 per cent during the past year. As experience is gained in this field of protection, it is felt that the deductible will be lowered and the coverage offered will be increased and that it will supplement or even supplant other types of insurance that are now being offered. As many of you well know, the Administration has been favorable to a reinsurance program which the medical profession has never accepted. With catastrophe insurance now available, reinsurance should not be necessary. *James P. McMullen, M.D. Medical Problems in West Virginia. West Virginia M.J. Oct. 1955.*

# CORRESPONDENCE

## Woman's Auxiliary greetings for 1956

Our auxiliary ship of state is beyond the midway point in its 1955-56 cruise. The progress and smooth sailing we have enjoyed so far can be credited to everyone of you — the members of the crew.

An old gentleman once said: "Too soon old. Too late smart". A new year prompts one to consider this philosophy. As a unit, and as individuals, it is wise to look into the mirror of accomplishment to see the reflection of our adequacies and inadequacies. An objective point of view will bring steady progress and keep our ship on an even keel.

Let us resolve not to acquire a habit of negative thinking, for "As a man thinketh, so is he." A strong, determined faith in the auxiliary's objectives will insure the successful effect of our work. If we will strive to progress through loyal service and earnestly seek to develop a warm, infectious confidence in one another there will be generated such strength that all our tasks will seem easy.

At this time of resolutions, let us resolve to have a continued faith in the principles of the medical profession, which we serve as an auxiliary; faith in our work, and the leaders who direct it; faith in the integrity of each member to carry out assignments; faith in our country, and its leaders; and most significant of all, faith in God and thanksgiving to Him for the bounties bestowed upon us.

May the joy and meaning of the blessed Christmastime be with you through 1956, and this New Year bring full measure of good health, good friends and good fortune for all.

"Welcome Aboard!" once again, as we continue our voyage. We know we will reach home port successfully for the Captain of our ship is Someone greater than you and I.

Cordially yours,
Dorothy Young
(Mrs. Warren W. Young)
President, Woman's Auxiliary
to the Illinois State Medical Society

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## Clinics for crippled children listed for February

Twenty-one clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois Division of Services for Crippled Children. The Division will count 15 general clinics providing diagnostic orthopedic, pediatric, speech, and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 2 for children with rheumatic fever, and 1 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The February clinics are:

February 1 — Hinsdale, Hinsdale Sanitarium
February 2 — Tuscola, Veterans Foreign Wars Hall
February 7 — Vandalia, American Legion Building
February 9 — Macomb, St. Francis Hospital
February 9 — Elmhurst Cardiac, Memorial Hospital of DuPage County
February 9 — Litchfield, Madison Park School
February 9 — Springfield, St. John's Hospital
February 10 — Chicago Heights Cardiac, St. James Hospital
February 14 — E. St. Louis, Christian Welfare Hospital
February 14 — Peoria, Children's Hospital
February 15 — Carrollton, Carrollton Grade School
February 15 — Chicago Heights General, St. James Hospital
February 16 — Rockford, St. Anthony's Hospital
February 22 — Alton (Rheumatic Fever), Alton Memorial Hospital
February 22 — Elgin, Sherman Hospital
February 22 — Springfield (Cerebral Palsy), Memorial Hospital
February 23 — Bloomington A.M. (General) P.M. (Cerebral Palsy), St. Joseph's Hospital
February 24 — Chicago Heights Cardiac, St. James Hospital
February 28 — Effingham (Rheumatic Fever), St. Anthony's Hospital
February 28 — Peoria, Children's Hospital

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## American College of Surgeons sectional meeting

A Sectional Meeting of the American College of Surgeons will be held at the Hotel Schroeder, Milwaukee, February 27-29, 1956. One of the important subjects to be discussed at this meeting is the handling of mass casualties, to be presented by a panel of experts.

Among the topics to be considered are fractures in children, hypothermia in cardiac and general surgery, carcinoma of the prostate, tumors of the thyroid, cancer of the colon, intestinal obstruction, problems in operability, endometriosis, repair of nasal defects, and biliary tract surgery.

For complete information on this meeting and the official program, write H. Prather Saunders, Associate Director, A.C. of S., 40 East Erie Street, Chicago 11, Illinois.

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## Atlanta graduate medical assembly

The Annual Meeting of the Atlanta Graduate Medical Assembly will be held at the Atlanta Biltmore Hotel, February 20-22, 1956. An increasing number of physicians have been attending this Assembly each year, and for the 1956 program, the agenda has been streamlined and sharpened to incorporate the many features that have attracted the most favorable comment from those who have attended previous assemblies.

Physicians desiring more information and a complete program for the Assembly should write to Dr. A. Cullen Richardson, Chairman, Atlanta Graduate Medical Assembly, 15 Peachtree Place, N.W.,-Atlanta, Georgia.

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## Invitation to Hawaii

Treat yourself to a week or two in Hawaii in the springtime, why don't you?

That's an invitation it's a pleasure to pass along. It comes from the Hawaii Medical Association, whose members are celebrating their organization's Hundredth Anniversary this coming April 22 to 29 in proper "Hawaii" as well as medical fashion. There will be a short but worthwhile professional program on Monday and Tuesday mornings, a spectacular Centennial Celebration Pageant Tuesday night, and a traditional *luau* (Hawaiian feast to you easterners) Thursday night, with Polynesian entertainment.

This is the best time of the year to visit America's island paradise — clear, balmy days and cool, refreshing nights; spring flowers in profusion on the ground and in the trees; lovely island m— but you have the idea now, surely. Hawaii in the spring is always the greatest, and this is your chance to tie it into a professional meeting. It follows the American College of Physicians' session in Los Angeles, too. Write the Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii, for reservations application forms.

## American academy of allergy annual meeting

The 1955 annual meeting of the American Academy of Allergy will be held February 6, 7, 8, 1956 at the Chase Hotel, St. Louis, Missouri. There is no registration fee and guests are invited.

## Stepped-up promotions announced for army medical officers

Under revised promotion policies, physicians will be eligible for temporary promotion to the grade of major, lieutenant colonel and colonel one year sooner than other army officers, it has been announced by Major General Silas B Hays, the Army Surgeon General.

As a result of the policy, it is estimated that 390 medical officers will be promoted to higher grades during the period ending June 30, 1956.

Consideration is also being given to more rapid promotion of lieutenants to the grade of captain.

The action gives additional recognition to the long and expensive training required of doctors before they can qualify for army commissions. It was pointed out that these officers have at least nine years of training beyond the high school level while most other army officers have less formal education at the time they are commissioned.

With the majority of army medical officers now serving temporary two-year periods as a result of the Doctor Draft Act, accelerated promotions are another means of attracting career officers into the army.

## An invitation to a surgical program

The Metropolitan Chicago Chapter of the American College of Surgeons cordially invites members of the Illinois Medical Society to an outstanding program on "The Medical and Surgical Management of Duodenal Ulcer" at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago on Thursday, January 19, 1956 at 8:00 p.m.

Dr. Walter C. Alvarez will be the moderator. The following men will speak and sponsor their residents on the following topics: Dr. Karl A. Meyer on the Resection Theory, Dr. Lester R. Dragstedt on Surgery and Vagotomy, Dr. Warren W. Furey on the X-ray Aspect of Duodenal Ulcer, Dr. Samuel H. Kraines on the Role of Psychiatry in Duodenal Ulcer. The Medical Management of Duodenal Ulcer will be discussed by Dr. Clifford J. Barborka and his medical resident.

The panel symposium will be followed by a Question and Answer period. Interns and residents, likewise, are urged to attend.

## Postgraduate courses at university of Michigan

The following courses will be presented at the University of Michigan by the Department of Postgraduate Medicine during 1956.

Internal Medicine
- Diseases of the Heart ..... March 12-16
- Electrocardiographic Diagnosis ..... March 19-24
- Metabolism and Endocrinology . March 26-30
- Diseases of Blood and Blood-Forming Organs ..... April 2-6
- Diseases of Gastro-Intestinal Tract ..... April 9-13
- Recent Advances in Therapeutics .....April 23-27

Ophthalmology ..... April 23, 24 and 25
Otolaryngology ..... April 19, 20 and 21
Pediatrics Obstetrics and Gynecology ..... January 23-28
Radiology, Diagnostic ..... April 2-6
Radio active Isotopes, Clinical Use of ..... As arranged
Basic Sciences ..... October-June

Further information and application blanks may be obtained from:

John M. Sheldon, M.D.
Director. Department of
Postgraduate Medicine
1610 University Hospital
Ann Arbor, Michigan

## International academy of proctology

Plan now to attend the 8th Annual Teaching Seminar of the International Academy of Proctology at The Drake Hotel, Chicago, April 23 to 26, 1956. The International, National, and Local Program Committees are planning an unusual seminar on anorectal and colon surgery.

There will be special emphasis on anorectal presentations, and on panel discussions, as requested by those who attended the New York meeting in 1955.

Eminent speakers from all parts of this country and abroad will present interesting papers and motion picture demonstrations of their personal techniques. Mexico is expected to be very well represented at this meeting.

The Delegates and Trustees, and their wives, are cordially invited to cocktails and dinner on Sunday evening, April 22, the evening before the official opening of the scientific activities of the convention. Both members and nonmembers plan to attend the Thursday night, April 26 banquet. The Banquet Committee promises the best cocktails and hors d'oeuvres in Chicago (prepared by the masters of the Drake cuisine), and the finest dance music and entertainment for your pleasure.

The Women's Auxiliary has planned an unusual program for wives of members and their guests.

Please remember that all physicians and their wives are cordially invited to attend the Annual Teaching Seminars of the International Academy of Proctology, whether or not they are affiliated with the Academy. There is no fee for attendance at these teaching sessions of the Academy.

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## Chicago Clinical Conference

The 12th annual Clinical Conference of the Chicago Medical Society will be held in the Palmer House, February 28-March 2. Prominent physicians from many parts of the country will present papers and participate in panels.

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## Hiatus hernia

The congenitally short esophagus is just what the name implies — an esophagus of insufficient length that pulls the stomach up through the esophageal hiatus; hence the cardio-esophageal juncture is above the diaphragm. The esophageal hiatus usually is large and the amount of stomach above the diaphragm changes little with a change in position from the horizontal to the Trendenlenburg. In order to be sure of the diagnosis, the esophagus must be well filled with barium and the patient is rotated into the oblique projections to be certain that the esophagus does not pass behind or beside the highest portion of the stomach. In the extreme form of this deformity, the entire stomach may be thoracic and the duodenum may be situated in the hiatus. *Seymoure Krause, M.D. and Pasquale Solinas, M.D. Hiatal Hernia. Pennsylvania M.J. Nov. 1955.*

# NEWS of the STATE



## ADAMS

**Personal.**—Dr. Thomas C. Bunting, Quincy, was elected a member of the Adams County Medical Society, November 14.

## COOK

**Physician Honored.**—Dr. Stanford T. Bolstead, who has practiced on the west side of Chicago for thirty-six years, was given a surprise dinner, December 4, 1955 in Nielsen's Restaurant, Elmwood Park. Two hundred and twenty of his patients gave him and Mrs. Bolstead a standing ovation when they entered the room. When dinner was over, Louis Morgano, River Forest, presented the physician with a scroll signed by all the guests. It contained the inscription "In due recognition for his service to humanity above and beyond the call of duty." Dr. Bolstead was also presented with a wrist watch and a check for $225.00. In making the presentation, Mr. Morgano said 'There's too much paying honor to a man after he's dead. That's why we wanted to give our doctor a little party tonight. He has done so much for so many people. We want him with us for another thirty-six years." Patients recalled how they had met Dr. Bolstead soon after he was graduated from Loyola University Medical School in 1919. His first office was at Jackson Boulevard and Western Avenue where he practiced for thirty-two years. Then he moved to 5227 Madison Street. Dr. Bolstead is a member of the staff at Norwegian American Hospital.

**Samuel Zakon Wins Honor.**—Dr. Samuel J. Zakon, professor of dermatology at Northwestern University Medical School, was elected to the newly created position of historian of the American Academy of Dermatology and Syphilology at its recent meeting in Chicago. Dr. James R. Webster was re-elected secretary-treasurer of the academy.

**Commonwealth Fund Gives Half Million to University of Chicago.**—The Commonwealth Fund of New York City has given $500,000 to the Division of Biological Sciences of the University of Chicago. The money is part of a $7,150,000 appropriation taken from its capital funds to finance unrestricted grants to 10 university medical schools in this country. According to the Chicago Tribune, purpose of the awards is to help such schools "institute or maintain creative programs in medical education." The University of Chicago announced that the grant will be employed exclusively to strengthen education in "less popularly supported" areas of medicine.

**Anonymous Gift to Evanston Hospital.**—A contribution of $300,000 was received by Evanston hospital from an anonymous donor who is interested in the educational side of the hospital. The gift was made with the request that it be used for two purposes: To create a medical library suite on the ground floor of the new hospital wing and to finance the conversion of the west building to apartments for interns and resident physicians pursuing graduate studies in the hospital. The west building is now used for patients suffering from polio and other contagious diseases, for patients under psychiatric treatment and for patients receiving general care. The proposed library suite will include the medical library, the librarian's office, a dictation room, the medical records room and stacks, and a study for members of the medical staff, interns, and residents.

**Lectureship Honors Leo Kaplan.**—Dr. Francis J. Braceland, psychiatrist-in-chief, Institute of Living, Hartford, Connecticut, delivered the inaugural address of the Dr. Leo A. Kaplan Lectureship at the Drake Hotel, November 29. Dr. Braceland discussed "Psychiatry in History and Literature." The lectureship was established by the Phi Delta Epsilon Foundation in honor of the late Dr. Leo A. Kaplan, assistant clinical professor of neurology and psychiatry, Stritch School of Medicine of Loyola University and formerly president of the Illinois Psychiatric Association.

**Dr. Cugell Joins Northwestern Faculty.**—Dr.

David W. Cugell, who has been directing the pulmonary physiology laboratory at the Thorndike Memorial Laboratory of the Boston City Hospital, has been appointed to direct new research laboratories for the study of diseases of the lung, heart, kidneys and blood vessels at Northwestern University Medical School.

The Northwestern laboratories, for which the department of medicine is seeking funds through private contributions, will expand the research and teaching facilities of the Florsheim Cardiac Clinic, established in 1938. The clinic was established in memory of the late Milton S. Florsheim, founder of the Florsheim Shoe Company and Northwestern trustee, by his widow and sons.

The clinic will move into larger quarters and include additional laboratories, examination and treatment rooms, and provisions for nursing care and social service. It will be on the third floor of the Montgomery Ward Memorial building at the Northwestern University Medical Center on the Chicago campus. The new laboratories, now being constructed and equipped, will provide opportunities for the study of nor only heart disease, but also lung, kidney and blood vessel disorders.

**Appointments to Chicago Medical School Faculty.**—Appointments to the faculty of the Chicago Medical School include the following: Dr. Irving C. Sherman, clinical professor of neurology and chief of the Division of Neurology; Dr. Lester Rice, clinical associate in medicine; Dr. William C. Maslow, clinical instructor in medicine; Dr. Lester Cohn, Dr. Stanley L. Leithold, and Dr. Fred Levit, clinical assistants in medicine; Dr. Alexander B. White, assistant in medicine; Dr. John E. Pauly, instructor in Gross Anatomy (full-time); Dr. Sidney H. Morgenstern, clinical assistant in orthopedic surgery; Dr. Douglas W. Mazique, clinical assistant in otolaryngology; Dr. Marija Mackeviciute, assistant in pathology; Dr. Seymour Metrick, clinical assistant in pediatrics and Dr. Julius Brant, clinical assistant in surgery.

**Northwestern Receives Bequest for Mental Disease Research.**—A sum of $390,000 for mental disease research at Northwestern University Medical School has been announced. Newspapers report that the grant was made in a court decision in Georgia. The University has been engaged in litigation in Georgia involving the will of a former Northwestern University professor, Charles L. Mix, newspapers reported.

**Michael Reese Dedicates New Unit.**—Michael Reese Hospital dedicated its new $3,500,000 M. S. Kaplan pavilion, November 6. The new six story structure is named in memory of Max S. Kaplan, Chicago scrap iron and steel executive who died in 1936. His widow, Mrs. Jennie M. Kaplan, and their nine children gave $500,000 toward the cost of construction of the building.

**Chicago Ophthalmologists Named to New Bi-Monthly Journal.**—Five Chicago ophthalmologists have been named section editors for the Survey of Ophthalmology, a new bi-monthly journal which appears in February 1956. The physicians are Drs. Bertha Klien, James E. Lebensohn, Austin Riesen, David Shoch, and Daniel Syndacker.

The journal, which will survey the world's current ophthalmologic literature with critical appraisals by the section editors, is under the editorial direction of Dr. Frank W. Newell, Chairman, Section of Ophthalmology, University of Chicago. It is to be published by the Williams & Wilkins Company of Baltimore.

**New Research Fund at University of Chicago.**—The May C. Willett research fund has been created by Howard L. Willett, Sr., who gave $100,000 in the name of his wife to the Lying-in-Hospital at the University of Chicago. Dr. M. S. Edward Davis, chief of staff at Lying-in, said the Willett fund will enable the hospital to embark on a study of unsolved fundamental problems, such as the inability of many couples to have babies, causes of premature birth and loss of babies through miscarriage.

**Arthur Dean Bevan Lecture.**—Dr. Owen H. Wangensteen, professor of surgery at the University of Minnesota, School of Medicine, delivered the Twenty-Seventh Annual Arthur Dean Bevan Lecture of the Chicago Surgical Society, October 7. The subject was "Current Accomplishments in Cancer of the Alimentary Tract With Special Reference to the Stomach and Colon."

**Charles B. Huggins Wins Borden Award.**—Dr. Charles B. Huggins, director of the Ben May Laboratory for Cancer Research and professor of urology at the University of Chicago School of Medicine, has been presented with the 1955 Borden Award in Medical Sciences. Dr. Huggins was nominated by a committee of the Association of American Medical Colleges, under the chairmanship of Dr. William St. Tillett of New York University College of Medicine.

The nomination was based upon his outstanding contributions in the field of cancer research, particularly that portion of the field that concerns itself with the relationships between the endocrine glands and cancer.

## HENRY

**New Officers.**—On November 9, 1955, the Henry County Medical Society chose the following officers to serve during the coming year: Doctors Robert M. Younglove, North Tremont Street, Kewanee, president; E. J. Goetzman, Baker Building, Kewanee, vice-president; William Larson, Annawan, secretary-treasurer. And Dr. C. Paul White, Kewanee, was named delegate to the Illinois State Medical Society and Dr. Anton Wellstein, Geneseo, was named alternate delegate.

## MADISON

**Personal.**—J. Mather Pfeiffenberger, Alton, was chosen president-elect of the Interstate Post-

graduate Assembly at the annual meeting held in Milwaukee during November.

**Society News.**—Dr. Frank R. Bradley, St. Louis, Administrator at Barnes Hospital, spoke before the Madison County Medical Society at St. John's Methodist Church, Edwardsville, December 1, on "The Hospital—The Doctor's Workshop."

**Fifty Years of Practice.**—Drs. Malfred Hamm and O. O. Giberson were inducted into the Fifty Year Club of the Illinois State Medical Society, November 10, at the annual dinner of the Madison County Medical Society. Presentation of the certificate and gold pin emblematic of the honor was made by Dr. Warner Newcomb, Jacksonville, Councilor of the Sixth District. Speaker for the evening was Dr. Groves B. Smith, Godfrey, who gave a most interesting and authoritative discussion on "Oriental Rugs."

## PEORIA

**Society News.**—Dr. F. Garm Norbury, President of the Illinois State Medical Society, Jacksonville, discussed "Some Factors in Mental Health" at a joint meeting of the Peoria Medical Society and its Women's Auxiliary in the Pere Marquette Hotel, November 15.

## SANGAMON

**State-Wide Meeting on Cardiovascular Diseases.**—The first state-wide scientific meeting on cardiovascular diseases was held at the Hotel St. Nicholas in Springfield, December 1, 1955 under the joint auspices of the Illinois Heart Association, Illinois Department of Public Health and the Sangamon County Medical Society. Speakers were Drs. William F. Dye on Cardiac Surgery; Bernard Schwartz, Diagnosis and Management of Rheumatic Fever; Paul F. Barker, Coronary Heart Disease; E. Grey Dimond, Instrumental Diagnosis of Heart Disease. Dr. Edward W. Cannady, East St. Louis, served as moderator for a panel discussion which concluded the afternoon session. In the evening, under the chairmanship of Dr. Stanley L. Levin, Danville, president of the Illinois Heart Association, greetings were extended by Dr. David J. Lewis, Springfield, president of the Sangamon County Medical Society. Speakers were Drs. Levin, on "Your Heart Association in Action" and Kenneth G. Kohlstaedt, "Management of Hypertension."

## VERMILION

**Elmer Hess Honored.**—Dr. Elmer Hess, Erie, Pa., addressed the Vermilion County Medical Society, November 1, 1955, on the physical structure of the American Medical Association which he currently served as president. Dr. Hess was honored at a reception preceding the meeting of the society, given by Dr. and Mrs. Harlan English in the Junior Ballroom of the Hotel Wolford.

**New Members.**—Dr. G. G. Curl was voted upon for permanent membership in the Vermilion County Medical Society, November 1, 1955. Doctors Alan Taylor, G. F. Van Gorder and Hugo J. Zotter were voted upon favorably for acceptance into membership as probationary members. These physicians will be voted upon again in one year for permanent membership, according to the Bulletin of the Vermilion County Medical Society.

## WARREN

**Crippled Children Clinic.**—The Warren County Medical Society sponsored its semi-annual clinic for crippled children at Monmouth hospital, November 10, 1955. A representative number of cases of diversified interest were seen. Some were new and some had been seen previously. The Clinic was well attended by local physicians. Dr. James Marshall, Monmouth, was chairman of the local committee and Dr. Richard Bennett, Chicago, was the clinician.

## WINNEBAGO

**Personal.**—Dr. Bruce Avery, formerly a general practitioner of Garwin, Iowa, is a new member of the Winnebago County Medical Society.

**Television Series.**—The following schedule has been announced for the television series "Your Baby and You" sponsored by the Winnebago County Medical Society. The series is presented on Fridays at 1:15 over WREX-TV. Physician participants and their subjects are: Dr. James C. Ellis, Dr. John Van Landingham, "Prevention and Emergency Care of Head Injuries"; Dr. W. Donald Jones, "Handling Baby"; Dr. Louis Rubin, "Skin Problems of Children"; Dr. King Woodward, Father's Role with the New Baby"; A. C. Maess, (not announced); W. L. Crawford, "Fitting the Baby into the Household Schedule"; Thomas F. Krauss, "Fevers"; Bruce R. Marshall, "Care of the Nose and Ears"; L. P. Johnson, (not announced); Kenneth D. Skaar, "Common Childhood Diseases"; and Fred F. Follmar, "Baby's Emotional Needs."

## GENERAL

**Conference on Physical Medicine and Rehabilitation.**—In December 8 and 9, a conference on physical medicine and rehabilitation was held for physiatrists and other personnel from twenty-two Veterans' Administration hospitals in this area, which covered eleven states. Dr. Louis B. Newman, chief of the physical medicine and rehabilitation service of Veterans Administration Research Hospital, Chicago, acted as chairman of the conference. The meeting was held at the hospital where Dr. Michael L. Matte is manager and Dr. Leonard A. Kratz is director of professional services.

**Willard Gibbs Medal Goes to Dr. du Vigneaud.**—The 1955 Willard Gibbs medal, awarded annually by the Chicago section of the American Chemical society, has been bestowed on Vincent du Vigneaud, Ph.D., chairman of the department of biochemistry at Cornell University Medical School. The presentation will be made in Chicago May 18, 1956. According to the Chicago Tribune, Dr. du

Vigneaud will be given the medal in recognition for his leadership of a research team which achieved the first synthesis of oxytocin, a hormone of the brain's pituitary gland, important in childbirth and lactation, and for other research accomplishments, including production of the first crystalline penicillin.

**Minnesota and Wisconsin Added to Valley Medical Society.**—After confining its activities for twenty-one years to the States of Illinois, Missouri and Iowa, the Mississippi Valley Medical Society is expanding to include the States of Minnesota and Wisconsin. This action was taken at the annual meeting of the officers, directors and trustees held at Quincy, Illinois, of November 20. The two new states will be headed by the newly created offices of Vice-President from Minnesota, to which Dr. Waltman Walters of the Mayo Clinic, Rochester, Minnesota, and Vice-President from Wisconsin, to which Dr. Arnold S. Jackson of the Jackson Clinic, Madison, Wisconsin, have been elected. Dr. Walters is the Chief Editor of the A. M. A. Archives of Surgery, and Dr. Jackson, the President of the U. S. Chapter of the International College of Surgeons. The other 1956 officers elected at the November 20 meeting were: President-Elect, Dr. George E. Kirby, Spring Valley, Illinois; Vice-President from Iowa, Dr. C. M. Zukerman, Davenport; Vice-President from Illinois, Dr. W. W. Fullerton, Sparta; Vice-President from Missouri, Dr. George T. Gafney, St. Louis; Secretary-Treasurer (22nd year), Dr. Harold Swanberg, Quincy, Illinois; Assistant Secretary-Treasurer, Dr. J. E. Reisch, Springfield, and Accounting Officer, Dr. Douglas M. Gover, Springfield, Illinois. Dr. Frank Peterson, of Cedar Rapids, Iowa, formerly professor and head of the Department of Surgery, State University of Iowa, is the 1956 President of the Society.

The twenty first annual meeting of the Mississippi Valley Medical Society will be held at the Hotel Morrison, Chicago, September 26-28, 1956. The American Medical Writers' Association will hold its annual meeting at the same hotel, September 28-29.

**"Your Doctor Speaks" on FM Station WFJL.**—The following physicians have recently appeared in transcribed broadcasts on FM Station WFJL, Thursday evenings, at 7:45 p.m. The series, entitled "Your Doctor Speaks," is presented by the **Educational Committee** of the Illinois State Medical Society:

**Eugene F. Lutterbeck**, attending radiologist, Radiation Center, Cook County Hospital, November 24, on Atomic Medicine.

**Clarence W. Monroe**, head of division of plastic surgery, Presbyterian and Children's Memorial Hospitals, December 1, on Misconceptions About Plastic Surgery.

**David I. Abramson**, professor and head of department of physical medicine and rehabilitation, University of Illinois College of Medicine, December 8, on Diseases Affecting the Blood Vessels of the Extremities.

**Casper M. Epsteen**, chairman of the department of maxillofacial and plastic surgery at Michael Reese Hospital, December 15, on The Psychological Importance of Plastic Surgery.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**John L. Archibald**, member of the staff at St. George's Hospital, Woman's Auxiliary to the South Chicago Branch of the Chicago Medical Society, December 10, on Safe Reducing.

**Joseph T. O'Neill**, Councilor of the second District of the Illinois State Medical Society, Deer Park Consolidated School P.T.A., January 3, on Child Behavior.

**Louise Tavs**, clinical assistant professor of dermatology, University of Illinois College of Medicine, Springfield Women's Club, February 18, on A Cosmetic is a Chemical.

**Raymond E. Robertson**, superintendent at the Institute for Juvenile Research, Women's Auxiliary, North Shore Branch of the Chicago Medical Society, February 23, on Mental Health.

**George H. Klumpner**, child psychiatrist at Institute for Juvenile Research, Aux Plaines Auxiliary to the Chicago Medical Society, February 24, on Mental Health.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Charles J. Smith**, clinical associate in obstetrics and gynecology, Stritch School of Medicine Loyola University, Henry County Medical Society at the Hotel Kewanee, Kewanee, January 11, on The Management of Prolonged Labor.

**Frederick L. Phillips**, attending pediatrician at St. Luke's Hospital, Lee-Whiteside County Medical Societies at the Plum Hollow Country Club, Dixon, January 19, on Erythroblastosis Fetalis and Exchange Transfusion.

**Max M. Montgomery**, associate professor of medicine, University of Illinois College of Medicine, DeKalb County Medical Society at the Bishop McLaren Foundation, Sycamore, January 24, on The Arthritis Problem and the General Practitioner.

**R. Charles Oldfield, Jr.**, a member of the staff of West Surburban Hospital, Oak Park, Whiteside-Lee County Medical Societies at Jul's Danish Farm, Rock Falls, February 16, on Bronchiectasis.

**Eugene J. Ranke**, assistant professor of medicine, University of Illinois College of Medicine, Stock Yards Branch of the Chicago Medical Society, Evangelical Hospital, February 17, on Medical Management of the Diabetic Foot.

## DEATHS

**Isaac Arthur Abt***, Chicago, who graduated at Northwestern University Medical School in 1891, died November 22, aged 87. He was professor emeritus of pediatrics at Northwestern University and consultant for Michael Reese and Children's Memorial Hospitals.

**Le Roy Branom***, Lincoln, who graduated at St. Louis University School of Medicine in 1919, died September 11, aged 75, of fracture of the femur and cerebral hemorrhage. He was past-president of the Logan County Medical Society and the Logan County Tuberculosis Association.

**Oran A. Brown,** Oak Park, who graduated at Rush Medical College in 1901, died November 11, aged 80. He practiced medicine in Davenport and Des Moines, Iowa, before coming to Oak Park.

**Margaret L. M. Buck,** Chicago, who graduated at Jenner Medical College, Chicago, in 1914, died November 3, aged 67. She was a member of the staff of the South Chicago Hospital.

**Charles T. Corwin***, Chicago, who graduated at Northwestern University Medical School in 1906, died September 24, aged 79, of cerebral thrombosis.

**Earle E. Culp,** Chicago, who graduated at Missouri Medical College, St. Louis, in 1896, died September 10, aged 80, of coronary thrombosis.

**Arthur H. Curtis***, Chicago, who graduated at Rush Medical College in 1905, died November 13, aged 74. He was professor emeritus of obstetrics and gynecology at Northwestern University Medical School.

**Francis Main Edwards***, Cisco, who graduated at St. Louis College of Physicians and Surgeons in 1898, died October 17, aged 79, of myocarditis and arteriosclerosis. He was consulting surgeon at Centralia for Southern Railway and surgeon-in-chief emeritus at St. Mary's Hospital in Centralia.

**Richard Cushing File***, Decatur, who graduated at the University of Maryland School of Medicine and College of Physicians and Surgeons in 1942, died August 30, aged 39, of glioma of the brain. At one time he was assistant superintendent and clinical director of Galesburg State Research Hospital, Galesburg, and secretary and treasurer of the Decatur and Macon County Hospital staff.

**Benjamin P. Graber***, Barrington, who graduated at Rush Medical College in 1922, died November 30, aged 60. He was a member of the staffs of Presbyterian Hospital, West Suburban, Oak Park, and of Sherman and St. Joseph's, in Elgin.

**Harold O. Jones,** retired, formerly of Chicago, who graduated at Rush Medical College in 1917, died November 26, aged 70, in Pottsboro, Texas, where he had lived since his retirement in 1948. He was professor emeritus of obstetrics and gynecology at Northwestern University Medical School.

**John E. McCorvie***, Peoria, who graduated at the University of Alberta Faculty of Medicine, Edmonton, Canada, in 1914, died October 29, aged 63.

**Edgar Garfield Merwin***, Highland, who graduated at Washington University School of Medicine, St. Louis, in 1907, died September 30, aged 76, of uremia, hypertension, and arteriosclerosis. He was a member of the staff of St. Joseph's Hospital.

**Glenn Earl Mershon***, Mount Carroll, who graduated at Barnes Medical College, St. Louis, in 1901, died October 8, aged 79, of coronary thrombosis. He was a member of the staffs of the Savanna City Hospital, and Deaconess and St. Francis Hospitals in Freeport.

**Frank C. Murrah***, retired, Herrin, who graduated at Rush Medical College in 1910, died October 21, aged 74. From 1935 until 1946, he owned and operated the Herrin Hospital.

**Morrell Pattengill,** retired, Cisco, who graduated at Rush Medical College in 1895, died in the Decatur and Macon County Hospital in Decatur, October 7, aged 87, of heart disease.

**Oscar B. Ragins***, Chicago, who graduated at the University of Illinois College of Medicine in 1922, died November 18, aged 62. He was head physician of the Municipal Tuberculosis Sanitarium Clinic at Provident Hospital, clinical associate professor of medicine at the University of Illinois, and a member of the staffs of Mt. Sinai and Cook County Hospitals.

**Eldo T. Ridgway,** Lebanon, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1906, died October 12, aged 74.

**Frank A. Schiltz***, Decatur, who graduated at the University of Illinois College of Medicine in 1951, died November 12.

**Leopold Schutz,** Chicago, who graduated at Schlesische-Friedrich-Wilhelms-Universität Medizinische Fakultät, Breslau, Prussia, Germany, in 1917, died September 6, aged 68, of heart disease.

**Max D. Shapiro***, Chicago, who graduated at Chicago Medical Schools in 1945, died November 28, aged 40. He was a member of the staffs of the American, Louis A. Weiss Memorial, and Franklin Boulevard Community Hospitals.

**Virgil R. Stephens***, retired, formerly of Berwyn, who graduated at Northwestern University Medical School in 1914, died in DeLand, Florida, December 2, aged 73. He had been a professor of surgery at the University of Illinois College of Medicine.

**John A. Wolfer***, Banning, California, formerly of Chicago, who graduated at Northwestern University Medical School in 1908, died November 21, aged 74. He was professor emeritus of surgery and at one time director of the tumor clinic at Northwestern University. He was a former attending surgeon at Passavant Memorial and Cook County Hospitals, and was past president of the Northwestern University Medical School Alumni.

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1. Howell, T.H.; Harth, J.A.P., and Dietrich, M.: Practitioner *173*:172.
*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

# BOOK REVIEWS



Bickham-Callander SURGERY OF THE ALIMENTARY TRACT Volume I, II and III
By: Richard T. Shackelford, M.D. Assistant Professor of Surgery, Johns Hopkins University School of Medicine. Assisted by Hammond J. Dugan, M.D. Assistant in Surgery, Johns Hopkins University School of Medicine. $60.00 per set. Pp. 2575. W. B. Saunders Company, Philadelphia and London

As is indicated in the name "Bickham-Callander" these volumes follow somewhat the scheme of Bickman's original volumes of operative surgery. The author in the preface states: "this work presents nearly every operative procedure currently in use for repair of disease or injury to organs of the digestive tract. It differs however, in that I have offered an evaluation of every procedure described. Basing my comments on my own experience and on reports in the literature, I have indicated whether a given procedure seems to be the one of choice. For these procedures which do not seem to be the best, I have pointed out in what respects they are lacking. In addition I have described the diseases or lesions for which the operation is used and the stage at which it should be undertaken, I have elucidated the indications and contraindications to alternate procedures. Preoperative and post-operative care are described in detail."

The consideration of each organ begins with the anatomy of the subject, then the physiology. Following this there appears the information concerning anesthesia applicable for operations on this organ. Then is considered the various conditions that may arise from disease in, or trauma to this organ; and after this there are set forth all the operative procedures that have been devised for this specific lesion, with "arguments" pro or con for the use of one particular technique. The author considers very thoughtfully every item; for instance 197 pages are devoted to the esophagus alone. And following this space are the lists of references referred to in the text, noting subjects, authors and periodicals. This same practice is used throughout the three volumes. This makes for the completeness of the work and adds to its facility for enabling the reader to familiarize himself in toto for investigation of any subject within its scope.

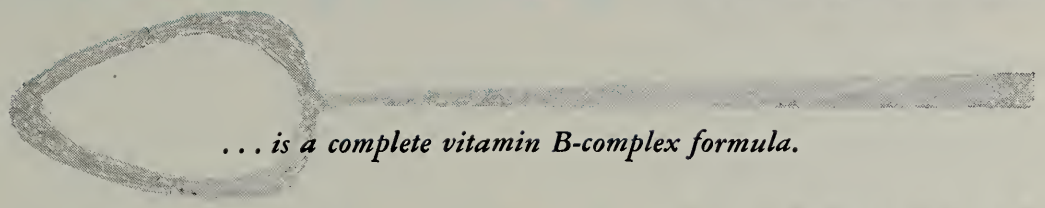
An unusual feature of these three volumes is the appearance at the end of each volume of the index complete for all three volumes. This makes for efficiency and facility in finding one's desired subject without looking in one volume alone. The idea is perhaps superior in practical use to a separate volume for indexing. And may we add, the index is most complete in detail in all subjects or phases dealing with any category.

This is primarily a surgical work, but medical care is closely correlated with surgical care and this is presented the complete clinical management.

The contents of the three volumes include Esophagus — Stomach and Duodenum — Liver — Gallbladder and Extrahepatic Biliary Ducts — Pancreas — Spleen — Small Intestine — Peritoneum, Omenta and Mesentery — Colon — Anorectal Tract — Excision of the Rectum — Hernia of the Gastrointestinal Tract — Incisions. "Operative Technique is explicitly detailed

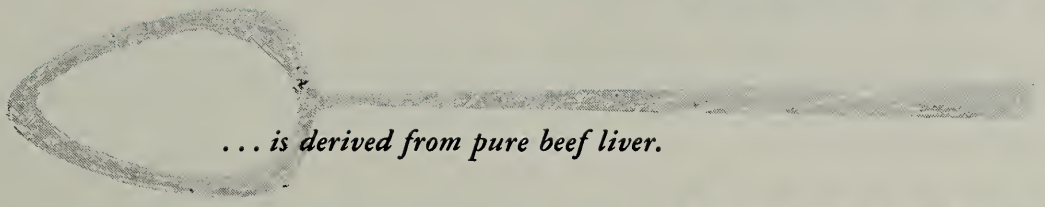
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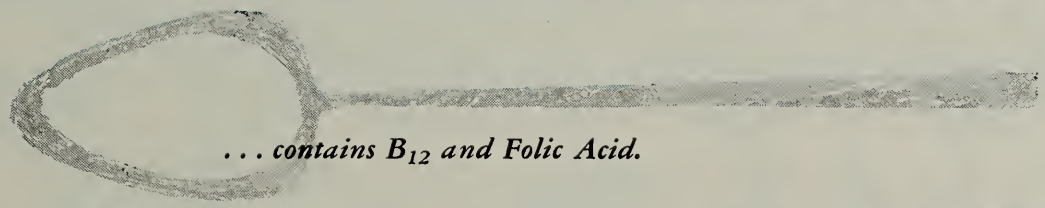
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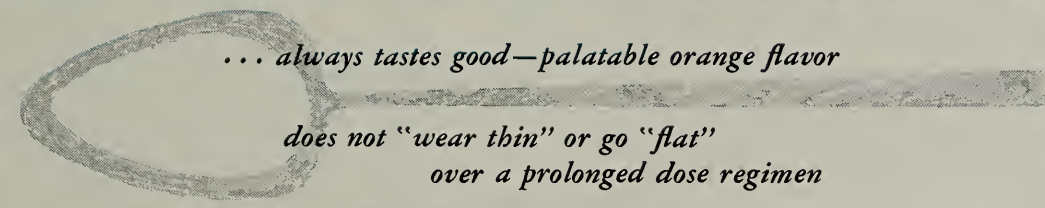
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## BOOK REVIEWS (Continued)

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These three volumes deserve a place in every surgeon's library. The younger surgeons should have them on their desk. For one to study these three books for a short time should make for Saunders a sale.

C. P. B.

‹ ›

HEART DISEASE, Emanuel Goldberger, M.D., F.A.C.P. New York. Revised 2nd Edition. $12.50. Lea and Febiger, Philadelphia, 1955.

This is a second edition of a previously popular and complete work on cardiology. Heart disease should be of paramount interest to all physicians as it is the leading killer of all diseases today. Much progress has been made in recent years in the field of cardiology which necessitates complete revisions of works such as this fine book by Dr. Goldberger.

The entire section on congenital heart disease has been expanded to bring out the many new developments since the first edition came off the press, and many other complete revisions are noted in this edition. The book is written so that it is of interest not only to cardiologists but to all physicians who care for patients with heart ailments.

The book is divided into five main sections. Section I describes in much detail the normal heart as determined by physical signs, fluoroscopy, electrocardiographic findings, and other diagnostic methods.

Section II describes the abnormal heart as shown by symptoms, abnormal physical findings, and other modern means of determining abnormal heart patterns. Section III is devoted to congestive heart failure, shock, syncope, anginal

*(Continued on page 50)*

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states, arrythmias, and neuromuscular cardiac disturbances.

Section IV describes cardiac abnormalities in general, congenital heart disease, rheumatic heart disease, hypertensive heart disease, and among other abnormal cardiac disturbances, diseases of the pericardium, aorta, etc.

Section V describes other conditions complicating heart disease such as pregnancy, surgery and anesthesia, and the current problem of employment of cardiac patients. Considerable attention is also given to the heart in endocrine disorders such as hyperthyroidism and hypothyroidism. These, as is generally known, frequently produce cardiovascular abnormalities which need careful attention.

A special chapter on cardiac trauma is also a valuable part of this book, as there are many people each year who receive stab wounds of the chest by accident or design which may necessitate emergency surgery.

This is indeed a fine book on cardiology which should be of general interest to all American physicians, who must be thoroughly familiar with the cardiovascular disturbances seen in millions of people.

‹ ›

DISEASES TRANSMITTED FROM ANIMALS TO MAN Thomas G. Hull, Ph.D. Secretary, Council on Scientific Assembly American Medical Association, Chicago. Fourth Edition, $12.50. Charles C. Thomas, Springfield, Illinois, 1955.

The first edition of this interesting book appeared in 1930. With the rapidly increasing knowledge of diseases transmitted from animals to man, the book now appears in its fourth edition. Dr. Hull had the assistance of 24 contributors in developing this fourth edition.

The book was prepared for the veterinarian, physician, health official and research worker, all of whom should be intensely interested in its contents. Since the first edition was prepared, more than 20 diseases have been proven to be transmitted to man from animals, which were not

*(Continued on page 54)*




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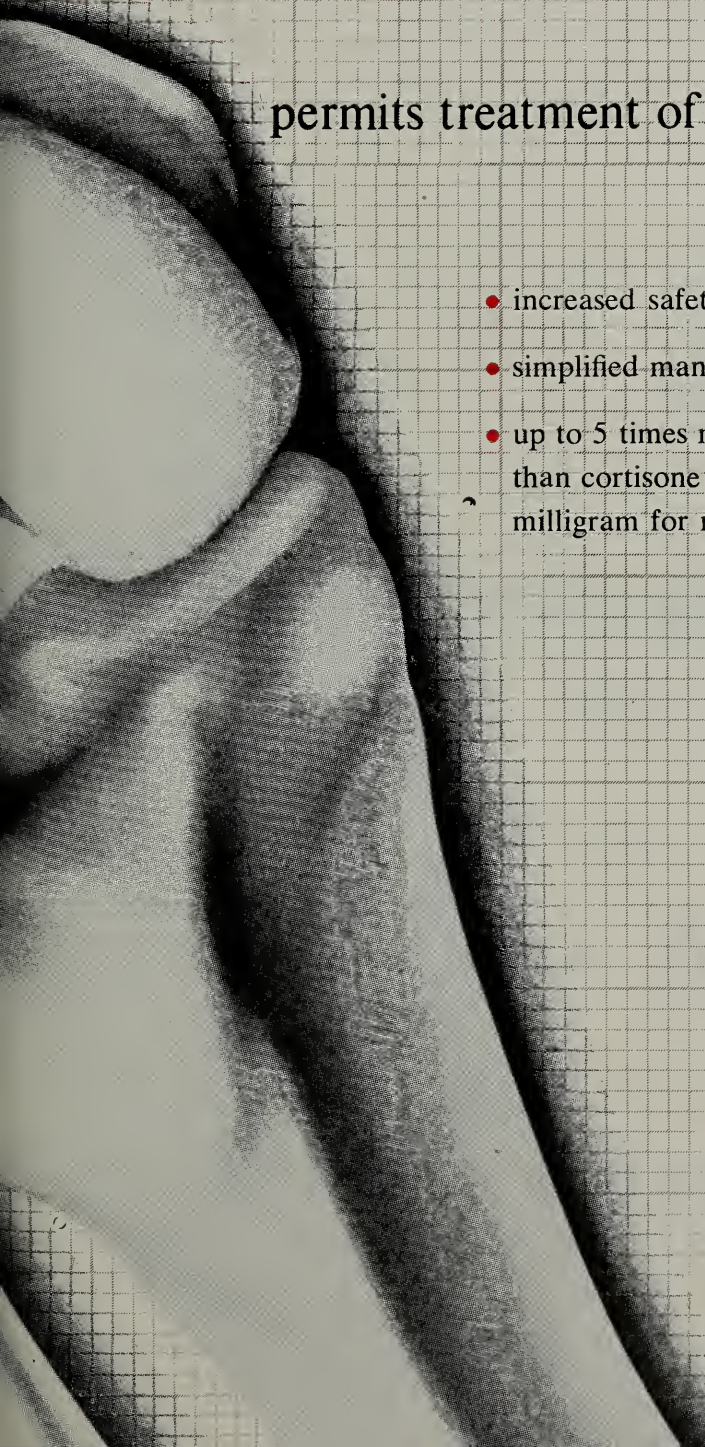
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## BOOK REVIEWS (Continued)

recognized as a menace to the well being of the human race in 1930.

This volume has been divided into three sections, the first dealing with diseases of domestic animals and birds, and occasionally of wild animals and rodents. The second section describes diseases of rodents and wild animals and occasionally of domestic animals. Section three describes in much detail the relation of human and animal diseases.

The book is well arranged and should be of interest to all physicians, as well as members of allied professions, many of whom do not thoroughly appreciate the fact that so many diseases of animals may be and frequently are transmitted to the human race.

Those of us who have known Dr. Hull for many years and who have seen the many fine scientific exhibits selected for the Scientific Exhibit at the regular A.M.A. meetings, know that anything he does is invariably well done. This likewise applies to his fine arrangement of the text in this fourth edition of an authoritative

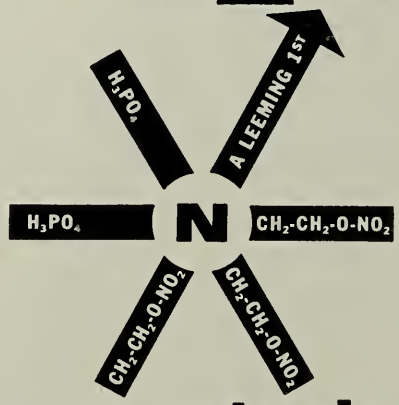
(*Continued on page* 58)

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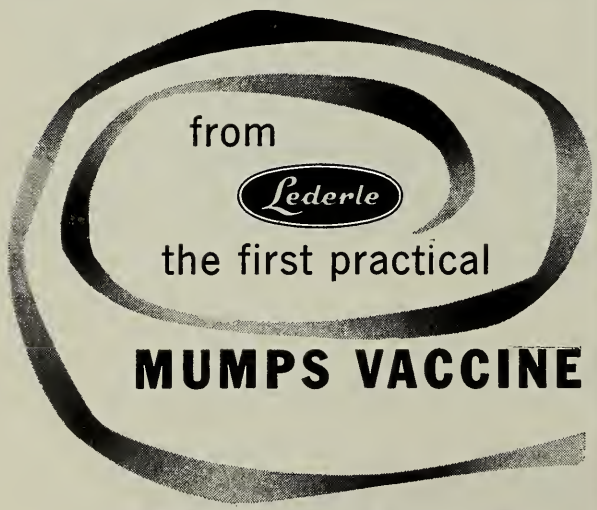
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## BOOK REVIEWS (Continued)

work. The book should be of general interest to members of the medical profession, veterinarians, and those interested in all phases of public health work.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

HYPNOTIC SUGGESTION — Its Role in Psychoneurotic and Psychosomatic Disorders — A Thesis. By S. J. Van Pelt, M. B., B. S., President of the British Society of Medical Hypnotists; Editor of the British Journal of Medical Hypnotism. Philosophical Library, 1956, $2.75.

FUNCTIONAL OTOLOGY — The Practice of Audiology. By Morris F. Heller, M.D., Assistant Attending Otolaryngologist for Audiology, Chief of the Audiology Clinic, The Mount Sinai Hospital, New York, with Bernard M. Anderman, M.A. and Ellis E. Singer, M.D. Springer Publishing Company, Inc., New York. $5.50.

HAND SURGERY IN WORLD WAR II. Edited by Sterling Bunnell, M.D. Office of the Surgeon General, Department of the Army, Washington, D. C.

RHEUMATOID ARTHRITIS AND PSORIASIS VULGARIS. Internal and Cutaneous Manifestations of the Permanent Endoparasitism in the Homo Sapiens. Their Common Etiology, Pathogenesis, and Specific Vaccine Therapy. By Tibor Benedek, M.D., Assistant Clinical Professor of Dermatology and Syphilology, Stritch School of Medicine, Loyola University, Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois. $12.00.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES. Volume 63, Article 2, Pages 145-318. Nutrition in Infections. Roy Waldo Miner, Editor. By W. A. Wright and 26 other investigators. Illustrated. $4.00.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES. Volume 63, Article 3, Psychotherapy and Counseling. By L. K. Frank, Rollo May and 46 other researchers. 108 pages, illustrated. $3.50.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES. Volume 63, Article 4, Biology of Poliomyelitis, by Habel, Enders, Francis, Koprowski, Melnick, Sabin, Salk, Shwartzman, Wilson, and 45 other leading authorities. $5.00.

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*—Bullein, W.: Government of Health, 1595.*

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Reports on these, and on many other medical attributes of wine, have been condensed into a small, readable brochure entitled—"Uses of Wine in Medical Practice." A copy is available to you—at no expense—by writing to: Wine Advisory Board, 717 Market Street, San Francisco 3, California.

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## American college of radiology statement on chest survey X-ray examinations

I. *Control of Tuberculosis*

Chest X-ray Surveys for the detection of *communicable pulmonary disease* are in the public interest. They should be conducted as part of a program to control and eliminate pulmonary tuberculosis.

To be effective, they require the following features:

1. Prior arrangements for prompt follow-up, medical examination and definitive diagnosis of all persons reported to have abnormal pulmonary X-ray shadows.

2. Prior arrangements for adequate medical care and hospitalization (under private or public auspices) of all persons found as a result of the survey to be in need of such.

3. Prior arrangements for adequacy of roentgen examination and interpretation. The size of film used in surveys is not of primary importance; the quality of exposure and processing is. The interpretation should be made by trained medical personnel, preferably pretested.

Many investigators recommend that all survey films be read twice. Such dual reading may be by one interpreter at two different sittings or by two independent interpreters.

4. Radiological supervision of the arrangement for and operation of the survey equipment is important in order to secure adequate protection of the technical and clerical staff, and adequate maintenance of high quality of film record.

5. Routine admission hospital survey X-ray examination of the chest is desirable as a protective measure in large general hospitals, mental institutions and other domiciliary units in which adults are housed in close propinquity, provided the X-ray reports reach the patients' charts promptly, and the attending physicians take suitable steps for prompt completion of diagnosis and necessary treatment.

II. *Control of Lung Cancer*

1. Semiannual chest X-rays of persons over 45 years of age have been advocated for this purpose. Experience with such surveys has resulted in the finding of a rather small number of controllable cases. The total yield in several

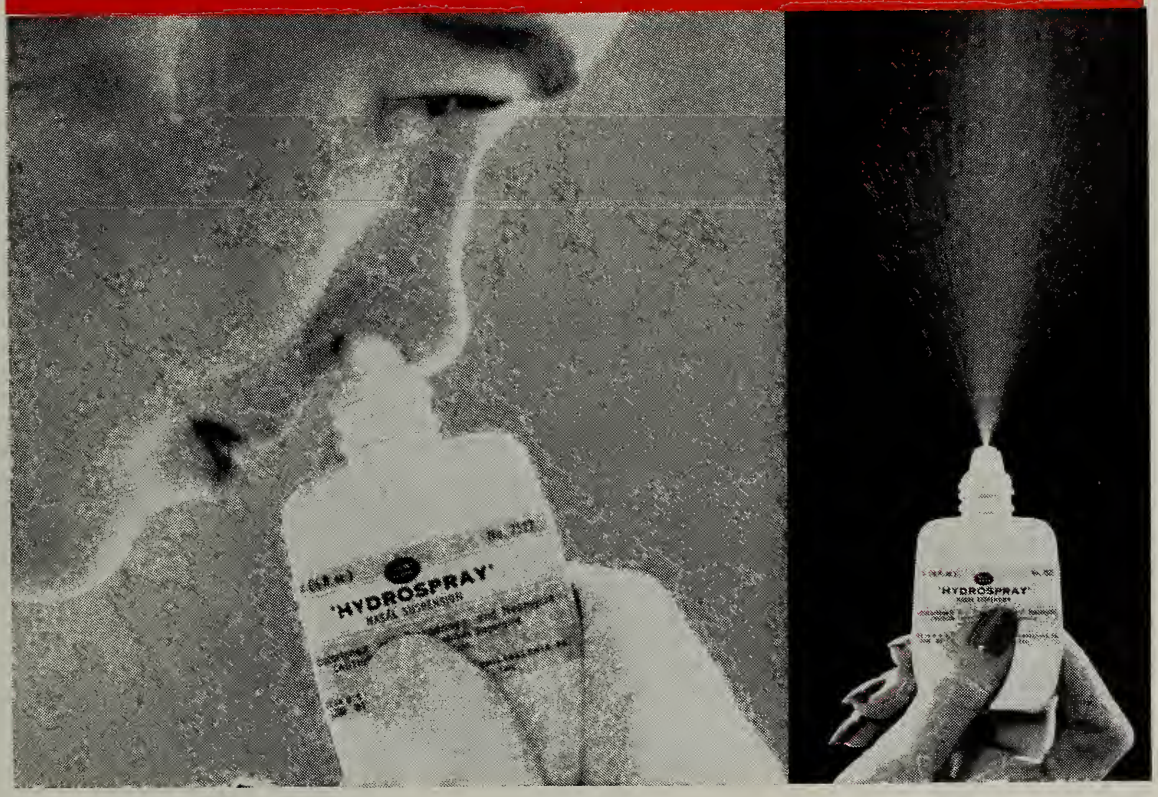
(*Continued on page* 66)

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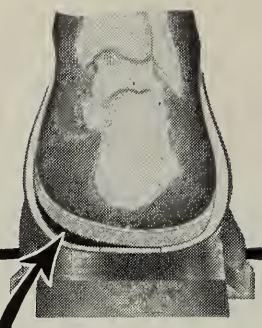
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**REFERENCE:** 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* **60**:431, Oct. 1954.

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## CHEST X-RAYS (Continued)

collected series has been about 10 cases of bronchogenic carcinoma per 100,000 persons (unselected population). If surveys could be limited to males over 45, the yield might reach 100 per 100,000. The collected three year survival rates have been about 12 per cent of the survey-detected cases.* In view of these facts, the American College of Radiology does not at the present time recommend mass chest X-ray screening as a practical or effective method for the detection of cancer.

2. If a pilot study on X-ray surveys for lung cancer is contemplated, it is recommended (a) that efforts be made to interest males over 45 years of age in the program, and (b) that interpreters be encouraged to note even minimal departures from normalcy.

3. Chest X-ray surveys for the detection of communicable disease may be utilized for the detection of patients with lung cancer. Where

*Multiphasic Surveys, California Med. 81:240, 1954. Garland, L. H., Chest Surveys: A Symposium, Radiology, 65:19. 1955; The Yield of Chest X-Ray Surveys, Editorial. JAMA 157:17, 1955.

(*Continued on page* 68)

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**CHEST X-RAYS (Continued)**

such surveys are being conducted, the same recommendations given under paragraph two for pilot studies should apply.

4. Persons found to have abnormal pulmonary X-ray shadows should have prompt definitive radiologic examination including, if necessary, body section films in addition to the regular clinical, laboratory and other examinations necessary for early identification of the shadow.

5. Negative reports in chest surveys may engender a sense of false security. Every effort should be made during the course of surveys to warn the individuals being studied as to the transient and unreliable character of negative findings.

6. The difference between cancer and tuberculosis should be borne in mind. Cancer of the lung may resemble tuberculosis, but if missed or undetected is almost certain to be fatal.

III. *Control of Heart Disease*

The most effective method for the detection of heart disease is believed to be regular clinical examination by a personal physician. X-ray surveys have aided in the detection of occasional cases, but the number so discovered early does not warrant continuation of the X-ray survey as a primary method for the detection of cardiac disorders. Nevertheless, the policy is recommended of reporting cardiovascular abnormalities of presumed clinical significance, where such are detected in survey films made for pulmonary disease.

IV. *Continued Research*

Members of the American College of Radiology are urged to continue their efforts to improve the quality of chest x-ray survey diagnostic procedures, to extend the trial of dual readings of all survey films, to continue arrangements for retrospective reviews of films of persons who develop pulmonary neoplasms, and to assist with the development of all methods for the earlier detection of disease.

## Rare

The trichina organism may lodge in any tissue of the body. One of the most rare locations is the tonsillar crypt. *Philip G. Piper, M.D. and Benjamin I. Brindley, M.D. Trichiniasis and the Tonsil. Wisconsin M.J. May* 1955.




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## Ulcerative colitis statistics

The complications associated with chronic ulcerative colitis which should have surgical consideration are: hemorrhage, obstruction, fistula formation, perforation, pseudopolypoid transformation of the mucosa, joint and skin diseases, and carcinoma. In addition, patients who are not yet rehabilitated by medical management, yet have gone into a state of remission of the disease, may eventually become candidates for colectomy. During the state of remission they often are underweight, have frequent attacks of diarrhea, and develop other complications as enumerated above. *Daugh W. Smith, M.D. Surgical Complications. J. Tennessee M.A. Sept. 1955.*

‹ ›

## More education

Despite all that has been written popularizing the signs, symptoms, and course of appendicitis, the public is still apathetic where serious medical symptoms are present whether they be those of carcinoma, tuberculosis, or appendicitis. Only by changing this attitude through constant education, will this problem be reduced in magnitude. *Edward J. Krieg, M.D. The Ruptured Appendix is Still with Us. Maryland M.J. Oct. 1955.*

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## Cortisone and gold

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Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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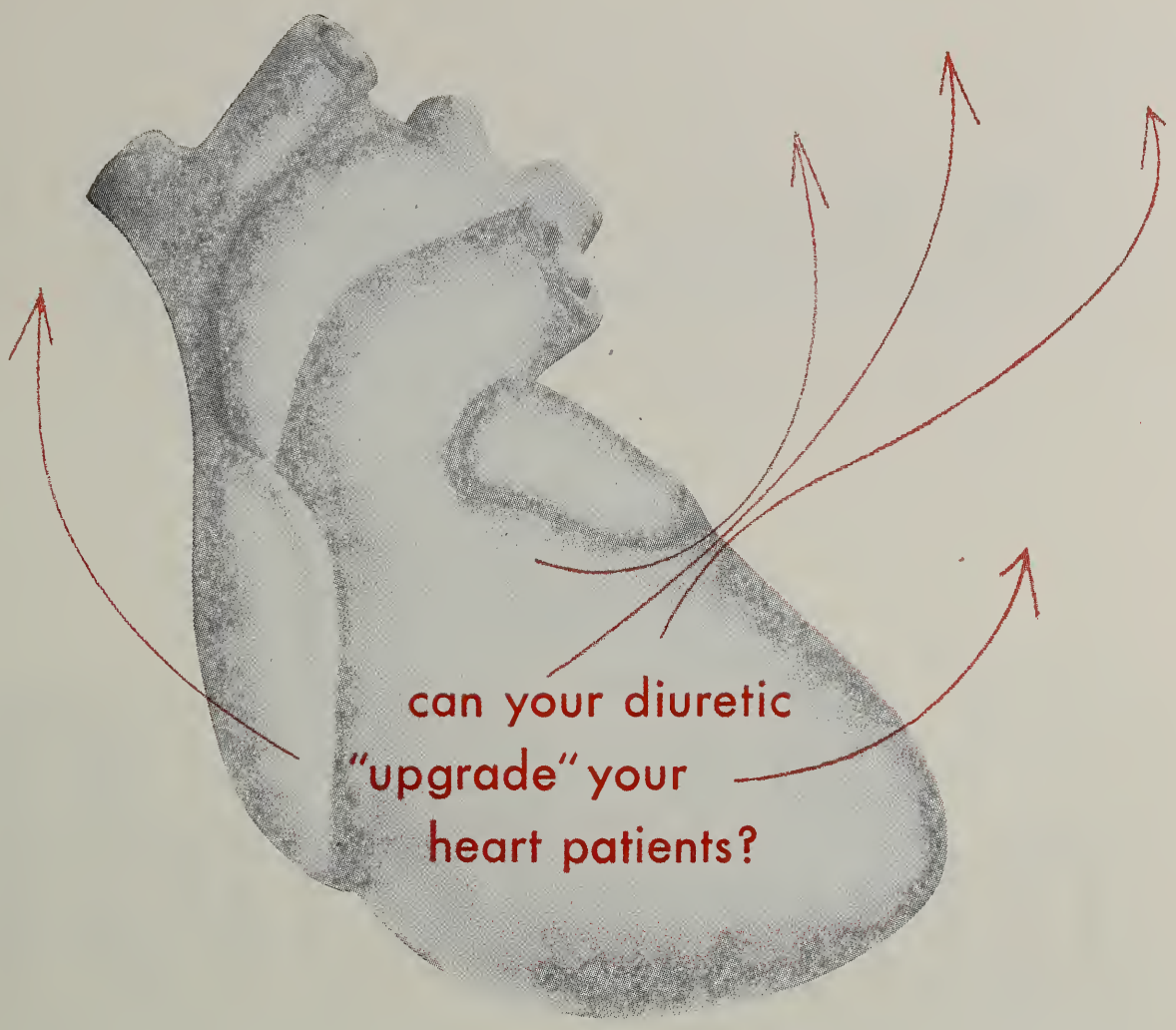
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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.


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# The Month in Washington

Washington, D.C.—Bills that have been hanging fire in Senate and House Committees for over a year finally are getting attention as the Administration pushes its program for broader and more uniform medical care for the families of servicemen.

A new version of a bill was dropped in the hopper on the opening day of this session by Chairman Carl Vinson of the House Armed Services Committee. It was designed in part to supply answers to a number of questions growing out of earlier versions sponsored by the Defense Department. Actually it raised more questions, which only hearings and testimony from expert witnesses and debate on the floor of Congress can answer.

The bill (H.R.7994) authorizes, as a matter of right, broad medical care for dependents of the armed forces as well as of Coast Guard, Public Health Service, and Coast and Geodetic Survey personnel serving on active duty. (The bill would authorize health insurance only for dependents of the latter three services.) Separate bills have been introduced in the past providing medical care for dependents of Coast Guard, PHS, and Geodetic Survey, but this marks the first time they are brought into the same bill with military personnel.

In provision of services, the bill has no surprises over its predecessors. It calls for diagnosis, treatment of acute medical and surgical conditions, treatment of contagious diseases, and maternity and infant care.

On another point of major interest to physicians, the bill drops out all mention of the hometown medical care plan, which was a part of Mr. Vinson's earlier bill. That bill contemplated use of civilian hospitals and doctors for those dependents who were not near military medical facilities and who had not taken out health insurance, with the government paying part of the cost.

Another area of almost certain debate in the latest bill is the insurance features. There are these main points:

1. A serviceman may elect to rely entirely on the chance of finding space available in a military hospital or clinic for his family, or he may choose protection through an insurance plan.

2. The family deciding on insurance has its choice of going to a military hospital or using civilian resources. The uninsured family could be charged by the military for out-patient care, and would have to pay subsistence costs while in the hospital.

3. A serviceman taking insurance would pay 30% of monthly premiums for a basic plan covering his wife and children, and the entire premiums for coverage of dependent parents and parents-in-laws. Parents and parents-in-law who found space in a military hospital, however, would be admitted on the same basis as wives and children.

4. Catastrophic-type coverage, at additional premium.

5. To take care of long term illnesses, the bill provides for transfer of dependents to military facilities once they have used up benefits in an

(*Continued on page* 36)

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Riker LOS ANGELES

**WASHINGTON (continued)**

insurance plan. Or if such transfer isn't feasible, the government could pay the additional costs for private care.

The bill was introduced before the Defense Department had completed a survey of Blue Shield, Blue Cross, and commercial plans to determine to what extent they could provide care under the bill. Conceivably the survey could further change the shape of an already much revised piece of legislation.

President Eisenhower in his State of the Union message summed up the case for dependent medical care this way: "Much has been done to attract and hold capable military personnel, but more needs to be done." He also broadly outlined administration plans in the health field, with emphasis on more money for research and federal aid to medical schools and to private research facilities for construction. With bipartisan bills along this line already before Congress, these proposals may move right along before adjournment in mid-summer.

However, Congress might decide that for this year medical schools should settle for the $90 million Ford Foundation money being made available to private schools to help strengthen teaching staffs.

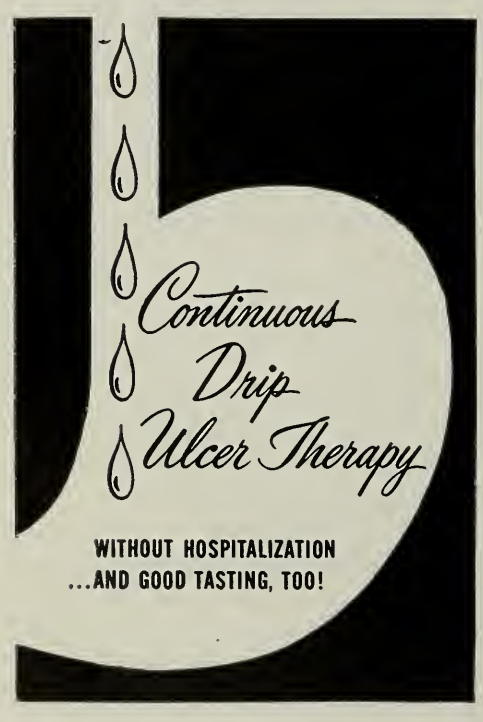
By the same token, there was some question just how much Congress would vote for Hill-Burton hospital programs this session in the light of the $200 million Ford grants to some 3,500 nonprofit hospitals.

A recent Public Health Service report indicates that states are now showing less preference for "public" Salk vaccine programs than they did a few months ago. The sixth allotment marked the high point in "public" preference. Then came a slight but steady decline.

‹ ›

## This is for Cole

The patient had had a cholecystogram and a biligrafin test. When we asked him for his history, he said, "I came up to the hospital and had a Billy Graham's test." *In England Now. Lancet, Dec. 3 1955.*


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*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

The
ILLINOIS
Medical Journal
Official Journal of The Illinois State Medical Society

FEBRUARY. 1956
VOL. 109 NO. 2

# Management of Atrial Fibrillation

ROBERT L. GRISSOM, M.D., OMAHA, NEBRASKA

ALTHOUGH atrial arrhythmia may occur in normal hearts, its chief importance is that it frequently complicates all the common forms of serious heart disease, contributing to the severity of that disease. In advanced stages of all types of cardiac failure, it is common; and its control depends, in large part, on dilatation of the heart chambers.

During the past half-dozen years, there has been considerable controversy over the mechanism of the arrhythmia. Current evidence is largely opposed to the theory that it is due to a circus mechanism, in which propagating impulses are supposed to stimulate progressive depolarization in the myocardium along a circular path which often includes the origin of the vena cavae. This older theory has given way somewhat to the opinion that multiple rapid firing foci are the real mechanism, and much experimental work and high speed movies have been produced to show this.[1,2,3] With aconitine stimulation experimentally, the fibrillatory source can even be shown to be a single focus. However, the occurrence of both large and small F waves in the electrocardiogram, as are usually recorded for a patient with atrial fibrillation, suggest multifocal sources.

The principal foci of the arrhythmia are presumed to be represented by the larger F waves, whereas the smaller waves are due to secondary foci which are less important and might not sustain or propagate the arrhythmia in themselves. The firing of these foci of beats proceeds at a rapid rate, upwards of 600 times per minute, a rate most inappropriate for sustained action by the ventricles, at least in humans. Accordingly, there is never any complete transmission of these impulses to the ventricle, and some degree of blockage of the impulses always exists at the atrial-ventricular junction. Whether the circle theory or this rapid tachysystolic source or sources theory explains the genesis of atrial fibrillation, or whether in some circumstances, the circle theory may best explain the arrhythmia, does not at the moment have practical importance in management. Our aim is either to augment nature's blockage of these impulses so that even fewer impulses get through to the ventricle, or to directly compel the atrial musculature to behave itself and revert to a regular sinus rhythm.

It is possible for this arryhthmia to exist in perfectly normal hearts, and we see students in school frequently who have episodes of paroxysmal atrial fibrillation and no other detectable

*Professor of Medicine, University of Nebraska College of Medicine*

*Presented before Section on Cardiovascular Disease, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955*

heart disease. In these persons the arrhythmia does not cause failure of the heart, but it does put the heart at a functional disadvantage, and the patient ordinarily has palpitation, especially after exertion.

The most typical occurrence of this paroxysmal fibrillation, however, is in the presence of rheumatic heart disease, particularly with mitral valve involvement. In this circumstance, the atria are enlarged, especially the left, and a normal pathway for depolarization might have a more devious route to follow, particularly when we know from commissurotomy auricular biopsies that Aschoff nodules are widely scattered through the muscle. The larger the atria, the more likely there is to be fibrillation.

This arrhythmia also occurs with various kinds of degenerative heart disease, coronary atherosclerosis, and in hypertension. In a study of patients after myocardial infarction,[4] ectopic rhythms occurred in about one out of five of the patients. The most common arrhythmia was premature beats; atrial fibrillation was next, accounting for one-fifth of all the arrhythmias. This arrhythmia also occurs with thyrotoxicosis, but the severity of degenerative heart disease from coronary involvement not the severity of the thyrotoxicosis correlates with the occurrence of fibrillation. Hence, atrial fibrillation does not occur as commonly in severe thyrotoxicosis in young persons as with relatively milder thyrotoxicosis in older persons. The management of fibrillation in these persons must include awareness of at least two disease processes, and in the older person we should always be alert to possible co-existing thyrotoxicosis.

It is conceivable that the presence of this arrhythmia might have certain benefits; for example, the occurrence of subacute bacterial endocarditis, always a hazard with rheumatic fever and rheumatic heart disease, is much less frequent in the patient who has fibrillating auricles than the patient who has a sinus rhythm.[5] Two large series indicate the incidence of fibrillation in subacute bacterial endocarditis is about 2-8 per cent whereas the incidence of fibrillation in non-subacute bacterial endocarditis patients with rheumatic heart disease may be 40-50 per cent. We are not sure of the reason for this, and most of those patients who have the arrhythmia with subacute endocarditis developed the arrhythmia during the course of the disease. This paradox, in which the arrhythmia protects from endocarditis, but occurs more often after the development of endocarditis, is unexplained.

Another possible advantage of atrial fibrillation is that in patients who have rapid rates that are difficult to control, the already existing atrio-ventricular block in all patients with fibrillation makes the ventricular rate easier to control by digitalis, when the continuing rapid heart rate might be injurious. Digitalis does not improve fibrillation; it improves the ventricular response to the fibrillating atria. For example, in mitral stenosis where rapid heart rate is always poorly tolerated, the ventricular rate may be much easier controlled than with sinus mechanism. Accordingly, the presence of atrial fibrillation is not a contraindication to commissurotomy surgery, nor does its presence appreciably increase the hazards of the operation. A similar situation occurs in induced surgical hypothermia. It has been reported that paroxysmal noctural dyspnea, and even angina, may be decreased after development of fibrillation.

On the other hand, there are hazards to the persistence of arrhythmia, the most common of which is pulmonary embolism. In the majority of mitral stenosis cases when embolism occurs, there is atrial fibrillation. Daley[6] has reported that in 167 patients with rheumatic heart disease and emboli, fibrillation was present in 90 per cent. Hall[7] reported that of 257 patients with fibrillation who died, 42 per cent had one embolus or more. A considerable number of the deaths in rheumatic heart disease are due to emboli, as has been reported by various authors. Sudden death may occur in any patient with heart disease, but it is not generally appreciated that from 2½ to 4 per cent of patients with fibrillation do die suddenly, often unexpectedly, many due to emboli.

Aside from the danger of embolism, the functional capacity of the heart is less efficient in the presence of fibrillation. When there is the stress of exercise, for example, there is an inordinate rise in the heart rate. In Figure 1, the irregularity of rate results in irregularity of the brachial arterial pulse wave, whose force is proportional to the preceding diastolic filling period and the volume of blood available for

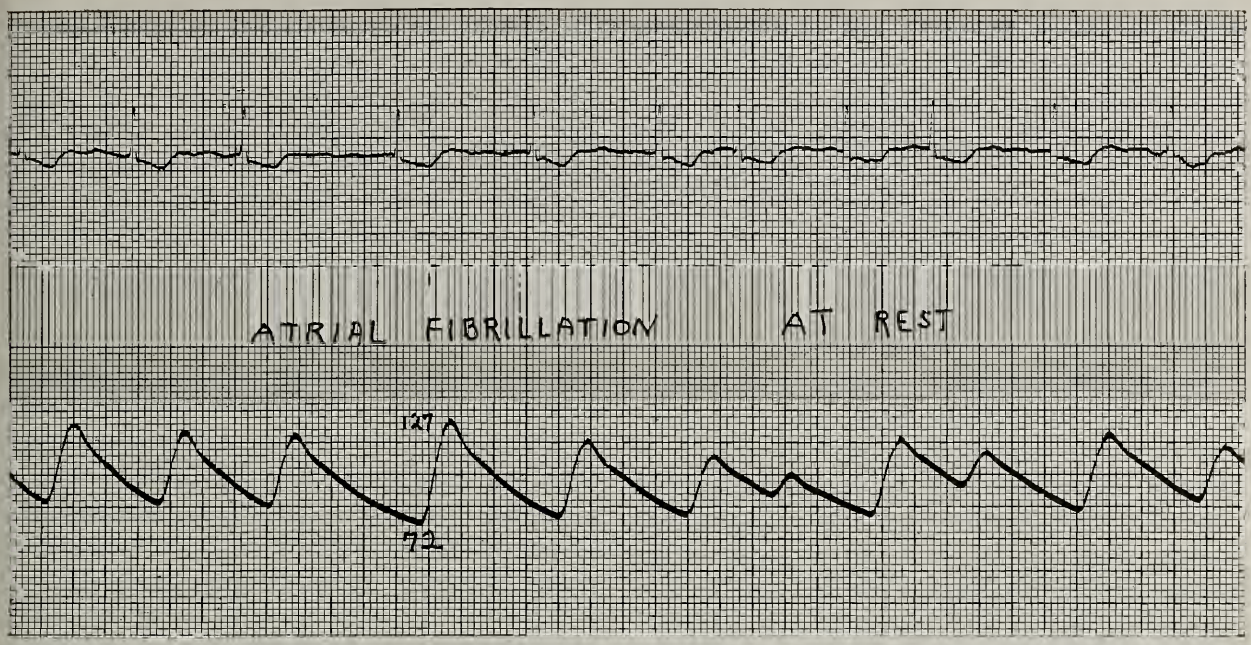



**Figure 1. Note irregularity of brachial arterial pulse wave dependent on length of preceding cycle.**

ejection. With exercise, as shown in Figure 2, the rate increase is greater than with sinus rhythm and at the expense of the resting period of the heart, an inefficient method sometimes resulting in decreased output. As a consequence of the inefficiency, the overall size of the heart increases, rendering the continuation of the arrhythmia more likely.

When long continued even in an otherwise normal heart, fibrillation may itself cause heart failure. In a study done by Phillips and Levine,[8] a group of patients at an average age of 50 had fibrillation without other evident heart disease; some of the group developed failure after a period of time. This heart failure could be reversed effectively by conversion of the arrythmia. Vital capacity then increased and heart size decreased.

If we accept that this is an undesirable arrhythmia, what sort of patients do we select for the attempt to change the rhythm? It seems reasonable that every patient who develops an

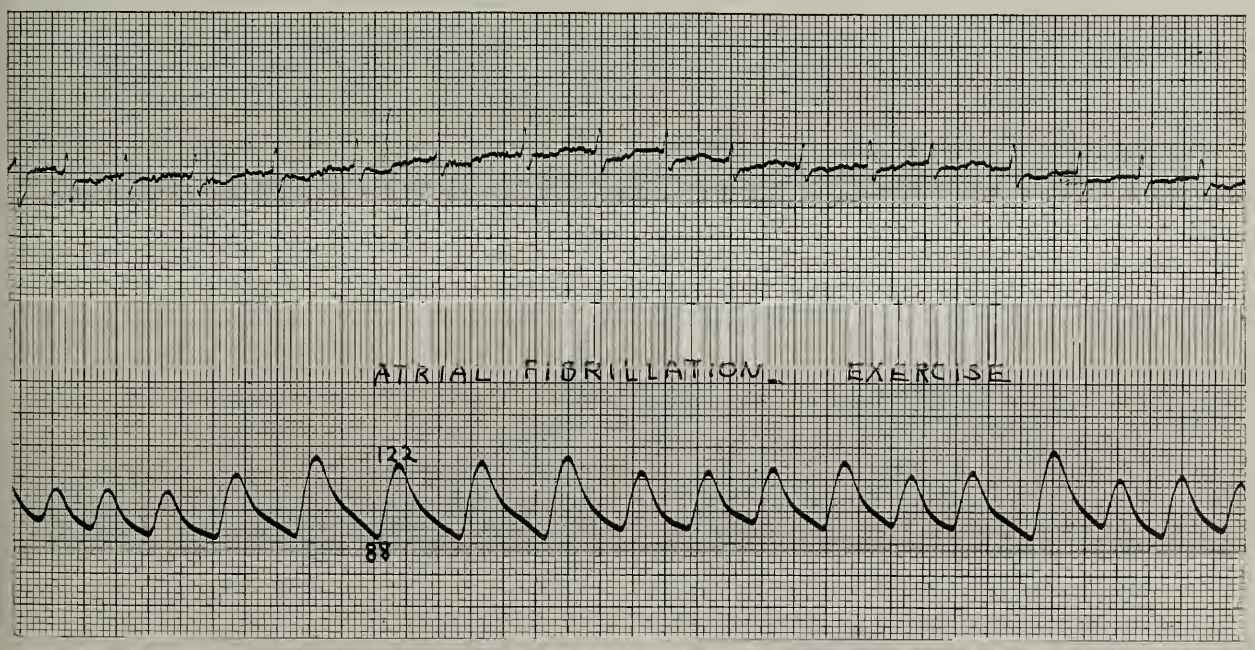



**Figure 2. With mild exercise pulse rate doubles, and pulse wave recorded from intra-arterial tracing shows less effective stroke volume.**

acute fibrillation should be treated unless spontaneous remission occurs. Also, all patients who have had thyrotoxicosis recently brought under control by surgery or radioiodine therapy. The easiest time to make this attempt at conversion is after euthyroidism is obtained. The patient who has a normal heart and chronic fibrillation should be converted as well as the patient who has minimal cardiac enlargement with considerable palpitation or other symptoms related to this irregular beating.

The next three groups of patients cause some hesitancy on the part of certain physicians to attempt conversion, but I would recommend them for your consideration. Patients who are having emboli should have the attempt, recognizing that an additional embolus may be discharged at the time the conversion is being done. In the long run, however, even with this hazard, the occurrence of serious or even fatal emboli is less after conversion to a sinus rhythm. Then there are those patients with mitral stenosis who by history began to do poorly with the onset of irregularity. A third type of these questionable patients in whom I believe an attempt should be made to revert are those who are incapacitated by heart failure, who have fibrillation, and in whom all attempts with digitalis and diuretics have been relatively unsuccessful. The possibility of achieving a satisfactory conversion is less than in other patients, but the restoration of cardiac competence by a regular rhythm may be so beneficial in the occasional successful patient, it is worthy of the trial and the risk.

A great deal of difference of opinion exists in one other type of patient. This is the patient with a well established atrial fibrillation who has no symptoms and has had no emboli. The only reason for attempting reversion is prophylactic, to avoid eventual cardiac enlargement, heart failure, or emboli. It seems to me each of these cases must be individualized and judged on its own merit. In general, the younger the patient the more enthusiastic one should be about attempting conversion. In elderly patients, the atrial fibrillation may exist with sufficient AV block that the ventricular response is already slow, even without the use of digitalis. Whether or not quinidine should be used in an attempt at reversion in such a patient is not clear cut, but most of us are inclined to leave them alone.

Let us assume that we have a patient who fits one of the categories favorable for conversion. How are we going to proceed with it? In general, it is a wise policy to have patients digitalized before attempting conversion, especially if the ventricular rate is rapid. Although large or toxic amounts of digitalis increase the dangers with quinidine and may prolong fibrillation, if the digitalis is kept in the therapeutic and not in the toxic range, there is no increased hazard to the use of quinidine with it. If the fibrillation is acute, if contraindications to digitalis are present, or if the ventricular rate is slow, there probably is no need for digitalis. The ratio between toxic and therapeutic amounts of digitalis decreases as heart failure proceeds, and excretion of digitalis is reduced in the older patient and in the patient with heart failure, so that a toxic amount of digitalis is more readily achieved.

In the presence of the acute arrhythmia, probably the overall best results are achieved with quinidine, although Pronestyl® (procaine amide) has a similar therapeutic effect. I believe quinidine should be used first, and if unsuccessful, then procaine amide may be tried. Because of similarity of action they should never be used together. If a single dose of quinidine is administered, its peak blood level is achieved in about two hours. The level begins to subside in four hours, is half gone by the end of eight hours, and entirely gone at the end of 24 hours. With quinidine, the fibrillatory rate of the atria slows roughly parallel with the blood level of quinidine. Since the blood level is at its peak in about two hours, it is logical to administer quinidine at two hour intervals. The dosage recommended,[9] therefore, is to begin with 3 gr. (0.2 Gm.) of quinidine orally every two hours and repeat five times during the day, making a total of 10 hours. It is not necessary to give a test dose prior to this regimen.

The patient is allowed to rest at night without additional medication, and it sometimes happens that the reversion is in the middle of the night at a point when the quinidine level is not necessarily at its highest. It is established, however, that the chances of conversion during the night are greater when a previous high level has been achieved during the day. Often sedation at night

helps or, in the elderly, oxygen. If a 3 gr. (0.2 Gm.) dose at two hour intervals for five doses the first day is ineffective, this same routine should be repeated the next day with twice the dose, 6 gr. (0.4 gm.) for five doses. Before each dose is administered, the rate should be checked to see whether or not it has become regular. Again, if unsuccessful, the third day 9 gr. (0.6 Gm.) are administered. It is not wise to go above this level in most cases.

Because there is some accumulation over a period of four or five days, it is well to repeat this same dosage, 9 gr. (0.6 Gm.) every two hours for five doses for that period. It is possible to go higher than this if blood levels can be checked or if no toxicity is manifested. Usually at this dosage, however, some toxic signs begin to appear. True idiosyncracy to quinidine is uncommon; but as the blood level increases, look for signs of ventricular premature beats, vomiting, or diarrhea. Widening of the complexes in the electrocardiogram, unusually low blood pressure, or more rapid ventricular rate. Side effects cause the attempt to be abandoned in about 10 per cent.

If a total daily dosage of 3 or 4 gm. of quinidine in the 10 hour period has not achieved conversion after a period of three days, the likelihood of being able to convert drops from about 80 per cent which it was when you started, to about 30 per cent. Some recent evidence[10] in 215 attempts in 179 patients with established fibrillation showed satisfactory conversion in 80 per cent nonrheumatic heart disease patients and 52 per cent in rheumatic patients at a serum level of 5.7 mg. Are serum levels necessary? I think not, unless dosages above 3-4 Gm. per day are contemplated. They are splendid to have, but not commonly available.

It is possible to use less frequent intervals and to use the drug throughout day and night. We have mentioned that the blood level of quinidine begins to fall off in four hours, and it may be unwise to make the interval any greater than four hours. Every four hours is a satisfactory method also but is extends the dosage often to the evening and sometimes during the night when a physician is not readily at hand to watch the progress of the arryhthmia.

Do these patients retain their reversion after they are once converted? Usually, yes. The maintenance of sinus rhythm is effective in up to 90 per cent of those in whom a satisfactory conversion can be made initially provided quinidine is continued. A mistake is made, I think, in not continuing quinidine once the patient has been treated, particularly since the dosage required to maintain sinus rhythm is less than that required to revert to sinus rhythm. How long the patient should stay on quinidine is questionable. There is no great hazard to continuing the quinidine indefinitely at a rate of 3 gr. (0.2 Gm.), three or four times a day, or for a period at double this dose year in and year out. If fibrillation occurs a second time, the difficulty in reversion may be greater than it was after the first time.

I have mentioned the hazard of emboli, both during chronic or established fibrillation and during the conversion. Is there anything that can be done to prevent this most serious hazard which always leads the physician and patient to believe that when it occurs during his ministrations that the drug may have had something to do with it? If a reliable laboratory is available, the patient co-operative and the physician experienced, then anticoagulants can be given for a two to three week period before reversion is attempted. This ought to be done in those who have had emboli recently, especially when there is a large atrium such as complicates rheumatic mitral valve disease. At present, the use of anticoagulants before all attempts at conversion is not warranted, although again individual judgment should be used.

What about that large group of patients who cannot be reverted or in whom, because of the background disease, we elect not even to make the attempt. For these patients, the proper control of the ventricular rate is most important. One of the digitalis products is certainly indicated, and because a relatively constant blood level of digitalis is important, the longer-acting products are slightly superior to the shorter acting digitalis glycosides. Crude leaf or digitoxin, therefore, seems to have widest use. There is no reason to give quinidine to a patient with atrial fibrillation when he persists in having that arrhythmia, unless an attempt is being made to revert it. It has no cardiotonic action. As most of these patients eventually develop failure, a shorter acting glycoside with a wider therapeutic

to toxic ratio may become more desirable in later stages.

The full therapeutic dosage of digitalis, or its glycoside, is about two-thirds of the amount that produces toxicity. The difference between these becomes less wide as heart disease progresses. At this point, the therapeutic dosage may not have been fully reached, even when toxic levels have been obtained. It is in such a case that a product like gitalin, which is said to have less toxicity at a full therapeutic level, may be indicated. When the comparative maintenance dosage of digitalis crude leaf is 0.1 or 0.2 Gm. per day, and the dosage of digitoxin 1/1000 of this amount at 0.1 mg. or 0.2 mg., the dosage of gitalin is abut 0.5 mg. These average doses may fluctuate upwards or downwards in any given case.

Is there any reason to give prophylactic medication? For example, should the patient with chronic heart disease and large atria be given quinidine prophylactically to prevent the occurrence of eventual fibrillation? This is not common practice but has much to recommend it. Before a patient with fibrillation develops an established arrhythmia, he will often have periods of palpitation and premature beats, which serve as a warning that fibrillation is impending. In such patients, the prophylactic use of quinidine given in the same manner as after reversion of established fibrillation, is indicated. This is often practiced after myocardial infarction, but should be done also in rheumatic disease.

As a rule, quinidine should be given orally. It can be given intramuscularly in the form of a gluconate, sulfate, or lactate but its toxicity is greater when given in parenteral form, and, except with vomiting, there seems to be no reason to give it in this fashion. If arrhythmias threaten, as shown by premature beats, it is sometimes helpful to use intramuscular quinidine during surgery prophylactically; some clinics use it before and during catheterization, but most believe it unnecessary even when the tube is tickling the heart. Only in emergencies should it be given intravenously, and then only when electrocardiograms are taken continuously.

## SUMMARY

Sir Thomas Lewis, when he wrote originally about quinidine, said "when in a case of auricular fibrillation, the normal rhythm is restored, the gain to the patient is considerable." It is recommended that we use quinidine much more widely than we are presently using it, in an attempt to revert and keep reverted these special types of patients with established auricular fibrillation.

Quinidine is our most reliable drug in the correction of established fibrillation and should be used, as a rule, after digitalization. Its toxicity usually is mild and relatively unimportant, although occasionally it may be serious and rarely, fatal.

If precautions are taken against emboli, and the electrocardiogram and other signs of toxicity of quinidine are heeded, and the proper dosages are not exceeded, it is a most effective drug, and the benefit to the patient is dramatic. Pronestyl is a drug of second choice principally effective after relatively recent onset of arrhythmia.

Always the risk of the fibrillation must be weighed against the risks and benefits of treatment; if the risk is great, it should be recognized but not feared.

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# General Anesthesia in Dentistry

**Francis M. Grem, M.D., Oak Park**

IN DEALING with patients undergoing dental surgery, some basic problems are immediately faced which are not usually encountered in patients undergoing operations on other parts of the body. For one thing, the dentist will encroach upon the airway of the patient in pursuing his operative procedure and this creates a problem which must be resolved with the greatest safety to the patient and minimal interference with the operation.

In addition, a substantial number of patients who step into the dental chair may be classified as ambulatory and means for the effective and safe management of these patients must be readily available whether the procedure is to be performed in an office or in a hospital. Whereas it is standard procedure to have a physical examination and laboratory studies made for patients undergoing operations other than in dentistry, much neglect is encountered in properly preparing dental patients for office or hospital operative procedures.

The gravity and stature of some operations performed in dentistry have been underemphasized. It is customary for some to regard these procedures and all affiliated services used in conjunction with them as minor. If some are willing to classify an extraction of a molar tooth as a minor procedure, I cannot subscribe to such a classification, nor will I classify the anesthetic procedure in such an operation as minor. To any individual who has spent considerable time in administering general anesthetics, it is apparent that even short operative procedures requiring relatively short anesthesia time can be associated with the greatest danger. Equal vigilance and care must be given to all patients, irrespective of the apparent simplicity of the procedure.

For all patients who are to receive anesthesia to the stage of surgical anesthesia, the following routine preparatory procedures must be carried out, irrespective of the duration and severity of the operative procedure or whether it is to be done in office or hospital. A history must be taken of the status of the cardiac and pulmonary systems, the presence or absence of liver and kidney disease endocrine disturbances such as diabetes, hypothyroidism, or hyperpituitarism, allergies; and diseases of the nervous system such as epilepsy. A history must include information as to the patient's previous experiences with anesthetics of all types and particular heed must be paid to a previous untoward experience with any anesthetic agent. It is prudent to ascertain whether alcohol, tobacco, or habit forming drugs are used. A complete blood count and urinalysis should be obtained and, when indicated, other studies such as chest X-ray and EKG.

This paper is not intended to be an exhaustive discussion of the analgesic stage of anesthesia. Nevertheless, it might be well to point out certain features of analgesia which will enable the anesthetist to use this stage of anesthesia to the extent that it is capable of being utilized.

The first stage of anesthesia is characterized by obtundation of pain in varying degrees, without loss of consciousness, the degree varying with resistance of the individual to depressant drugs, the force of the pain stimulus, and the potency of the anesthetic agent. Resistance to depressant drugs will vary during different periods of one's life cycle and may be altered by other factors even during the same age group and in the same individual under various circumstances such as endocrine function, emotional status, presence or absence of pain or fever, and general well being of the individual. A 21 year old male weighing 160 pounds will have different degrees of resistance to depressant drugs when he has severe pain incident to an infected tooth and no pain in a carious tooth.

The nature of the pain stimulus plays a major role in the degree of obtundation of pain; If it is relatively minor, analgesia will be practically complete but, if it is severe, analgesia may not be complete. Complete analgesia will not be possible in a certain percentage of cases and it will be necessary to deepen the stage of

*Presented before the Section on Anesthesiology, 115th Annual Meeting Illinois State Medical Society, Chicago, May 17, 1955.*

anesthesia to the surgical stage to permit completion of surgical intervention.

The potency of various drugs used to produce analgesia varies considerably. It would be unwise therefore, to persist in attempting to achieve a satisfactory analgesic state with a weak general anesthetic agent when a more potent agent would be readily adaptable in the circumstances. Nitrous oxide is a pleasant and useful agent but because of its lack of potency it will fail to produce a satisfactory, physiologic analgesic state in a certain number of patients. In this group, the use of nitrous oxide alone should be abandoned, and a new agent substituted or used as a supplement to effect the desired state of analgesia.

Ethylene is a little more potent than nitrous oxide but it, too, often falls short of producing the desired analgesic state, and supplementation or replacement with another agent will be mandatory. Because of the explosive dangers associated with ethylene, its use as an analgesic agent is fast disappearing.

Trichlorethylene, despite its inherent toxic nature, possesses many desirable features as an analgesic agent and has become increasingly popular in the past few years as an analgesic agent for various dental procedures. Like all other anesthetic agents, it can be deadly, even when administered for what some would consider a minor procedure. There is one instance of cardiac arrest incident to its use as an analgesic agent for the changing of dressings in a burned patient, due to improper administration. This tragedy should stir some out of any false sense of security they may possess that trichlorethylene is perfectly safe when used solely as an analgesic agent. It must be used in an open system without the interposition of an absorber of soda lime life. It is a halogen containing anesthetic and should not be used in conjunction with epinephrine or in the presence of liver or kidney disease or where cardiac disease is associated with disturbances of rhythm. Like the other analgesic agents, it will not be successful in a certain number of patients for analgesic purposes and surgical anesthesia will have to be substituted.

Divinyl oxide has enjoyed popularity among relatively large number of anesthetists for the production of analgesia, especially in children. It is rapid and pleasant in action, but is associated with increase in salivation which can be a drawback in certain procedures.

In all instances where analgesia is to be achieved to the greatest degree, premedication and supplementation plays a large role in achieving the state desired. However, even with the use of these features, it will still not be feasible to utilize analgesia for some procedures and surgical anesthesia will be necessary.

All patients should be individually evaluated as to probable resistance to depressant drugs. Utilizing our powers of observation and reasoning, individual premedication should be administered to fit the particular patient undergoing a particular operation, using a particular anesthetic or group of anesthetic agents, under a particular set of circumstances. All patients should refrain from taking solid or liquid material by mouth after midnight, if the operation is to be performed in the morning, or for at least eight hours for afternoon operations. The heart and lungs should be examined as part of the preoperative physical examination and the pulse, blood pressure, and respiratory rate checked before and at frequent intervals during the operation.

Since the operation will entail encroachment upon the airway, an early decision must be made as to the safest and most efficient way the structure can be protected from obstruction. To this end, one of the greatest devices at our disposal is a good suction machine, which should always be immediately at hand and in working order. Failure to have a suction apparatus on hand is reason for cancellation of the operation. Needless to say, an ample and varied assortment of oropharyngeal and nasopharyngeal airways should be an integral part of the accessory equipment when a patient receives a general anesthetic for any purpose.

Where the operation will not consume much time and the encroachment on the airway will be minimal or of short duration, inhalation or intravenous anesthesia, without the introduction of an endotracheal tube, will be satisfactory. However, whenever the air passages may be seriously obstructed or the operation is to last more than a short period of time, endotracheal anesthesia is the wisest choice. For must purposes, oral endotracheal anesthesia is not quite

satisfactory, and the nasotracheal is preferred. Nasotracheal intubation may be performed blindly or under direct vision and will prove to be technically more difficult in the majority of cases. Spraying the nasal passages, the pharynx, and the larynx with a topical anesthetic will make intubation less tedious. Where nasotracheal intubation has to be performed under direct vision, the use of muscle relaxants will facilitate the insertion of the tube into the larynx with minimal trauma.

There is a wide variety of agents to produce surgical anesthesia. Some cannot be used alone, even when proper preoperative assessment has been made and preanesthetic medication given. In these cases, a combination of several agents will prove most practical. I will restrict my discussion to general anesthetics by the inhalation and intravenous routes. The most commonly employed agents for inhalation anesthesia consist of nitrous oxide, ethylene, cyclopropane. divinyl ether, diethyl ether, and trichlorethylene. Ethyl chloride and chloroform are used by a few anesthetists but these agents have never achieved wide popularity in the United States.

Nitrous oxide and ethylene are weak anesthetic agents and, even with proper premedication, are difficult to administer alone for surgical anesthesia. If they are utilized as the sole anesthetic agent, it is for relatively simple procedures of short duration. In most instances, they are used in conjunction with other agents, such as intravenous barbiturates, intravenous opiates, and inhalation agents of greater potency. Nitrous oxide-oxygen-ether and ethylene-oxygen-ether are examples of the latter combination, while intravenous Pentothal® combined with nitrous oxide-oxygen in a physiologic mixture or intravenous Demerol® combined with nitrous oxide-oxygen in a physiologic mixture are examples in the former categories. Some individuals have utilized nitrous oxide and ethylene in what they consider a successful manner by the introduction of oxygen deprivation, but I am not particularly desirous of duplicating their efforts and of recommending the procedure. Ethylene, either alone or in combination with other agents, should not be used when conditions exist which prevent the explosion hazard from being reduced to a minimum.

Diethyl ether and cyclopropane can be used most satisfactorily in all circumstances except where the explosion hazard has not been reduced to a minimum. Either agent can be used alone or in combination with other inhalation or intravenous agents for producing any degree of surgical anesthesia.

Divinyl oxide can be used alone for procedures requiring not more than 15-20 minutes, but its most successful use is in combination with nitrous oxide, in which cases it is vaporized by a steady stream of nitrous oxide flowing thru a chamber in which drops of vinethene are permitted to fall and become converted to a vapor. It is an explosive agent and all that was said about other explosive agents is applicable to divinyl oxide.

Trichlorethylene is nonexplosive and is pleasant to inhale, but should not be used for the production of surgical anesthesia. It was my good fortune, during World War II, to be stationed in a British hospital, where I had an opportunity to administer a small number of surgical anesthetics with trichlorethylene. Statistics showed that about 80 percent of the anesthetics administered were unsatisfactory because of the complications associated with the use of trichlorethylene for surgical anesthesia. While a variable percentage may be ascribed to my unfamiliarity with the agent to explain the high degree of complications, yet I was assured by those teaching me that even in the most competent hands, the percentage of complications was much higher than when chloroform of diethyl ether was used. I have used trichlorethylene as the sole anesthetic agent so infrequently since that time that I can not speak with any degree of accuracy on its successful use alone as an agent for surgical anesthesia.

The use of intravenous anesthesia, either alone or in combination with inhalation agents, has enjoyed wide popularity in this country for a great many dental procedures. A word of caution is warranted on the use of intravenous anesthetics alone for many dental operations. The rapidity and pleasantness of induction of anesthesia with intravenous barbiturates has caused this route to be widely used by various people with all degrees of training. Some claim outstanding success with minimal complications but others, more experienced and better trained, know the pitfalls of anesthesia and are ever on the alert to diminish untoward reactions and

complications by maintaining certain safeguards.

As with other forms of general anesthesia, a minimal fasting period of eight hours is mandatory and a parasympatholytic drug is essential. If the latter has not been administered when the patient arrived for the operation, atropine or scopolamine should be given intravenously 10 minutes before the administration of the barbiturate. A 2½ per cent solution of thiopental sodium administered by means of a needle and syringe or 0.5 per cent solution administered by intravenous drip are the most popular ways in which thiopental sodium is utilized. As soon as consciousness is lost, oxygen by nasal mask is started.

Because thiopental sodium is not a true analgesic agent and may fail to block afferent nerve impulses, it will be necessary to add nitrous oxide or ethylene to the oxygen except for very short procedures, in which case thiopental sodium can be employed as the sole anesthetic agent.

Whenever the operative procedure is to consume more than a few minutes time or whenever obstruction to the airway is likely to occur, irrespective of the duration of the anesthesia, tracheal intubation is to be considered the safest procedure to follow prior to starting the operation. In most instances, the nasotracheal route will be most desirable. If this is to be accomplished, one way of effecting this is to first spray the nasal passage on the chosen side, as well as the pharynx and larynx with a topical anesthetic.

Once this is performed and anesthesia is carried to the surgical stage, blind nasal intubation can be performed. If this proves tedious, nasal intubation under direct vision, with or without the aid of muscle relaxing drugs, can be achieved in all but a few instances. In the latter contingency, oral intubation will have to be adopted even though it may prove cumbersome for the operating surgeon. Once the tube is inserted, a moistened packing is placed carefully but firmly about the endotracheal tube to prevent foreign substances from entering the tracheobronchial tree by dripping or falling along the sides of the endotracheal tube. Protection can be afforded against this hazard by using an inflated cuffed endotracheal tube when intubation has been performed by the oral route.

Obstruction to respiration is the commonest complication encountered in administering barbiturates intravenously. A rather large percentage of the respiratory obstruction is accounted for by laryngospasm, caused either by direct contact of some foreign substance with the larynx or on a reflex basis. Laryngospasm may be transient or persistent. The former is usually unrecognized by those who have made extravagant claims for the unique safety accompanying intravenous barbiturate anesthesia from the standpoint of low rate of complications. The latter is usually not sufficiently appreciated by members of the same group.

On one occasion the author visited a clinic where a moderately large number of intravenous thiopental sodium anesthetics were administered incident to extraction of one or a few teeth. He was prepared to witness what, in his own practice, was largely an unattainable condition in which practically no complications accompanied this type of anesthesia. In the instance under discussion, approximately 250 cc. of a 2½ per cent solution of thiopental sodium were administered over a period of two minutes. With the patient in a depressed state and with the lower jaw relaxed, the operator (who also administered the anesthetic) inserted a mouth prop and proceeded to extract an upper second left molar tooth. Some difficulty was experienced in extracting the tooth and a small amount of bleeding occurred. The patient began to moan, made swallowing movements, and then suffered a bout of respiratory obstruction due to larynogospasm. The operator was more concerned with the success of removing the patient's tooth than with patient's condition, because no remedical action was instituted until the degree of cyanosis became quite alarming. Larynogospasm eventually was relieved, the tooth removed with the aid of infiltration anesthesia with procaine, and the patient made an apparent complete recovery. He could have died in the dentist's chair.

Other barbiturates are used for intravenous anesthesia in dentistry, including surital® sodium, but the author does not claim wide experience with their use in dentistry. In competent hands, the latter drug has proved as successful as thiopental sodium and has found increasing adherents since its introduction.

In most discussions on anesthesia for dental operations, reference usually is made to anesthetics given in the hospital or, in the case of office practice, to operations of limited duration. In the last part of this paper I should like to pre-

sent for consideration the feasibility of administering general anesthesia for prolonged office procedures. For some reason, it has become increasingly difficult to secure hospital beds for patients requiring dental care, and it often becomes necessary to refer these patients to other dentists who have staff privileges in hospitals. Even where the dentist has staff privileges, a variable period of delay is encountered in securing a bed. For these and other reasons a trend has developed toward doing extensive procedures in the office, under general anesthesia. As these patients are of necessity ambulatory, the problem becomes an imposing one. However, I believe that a solution is available if we "bring the hospital to the patient, if we can't bring the patient to the hospital."

This can only be effected if we create hospital-like facilities in the office. A faint hearted approach is to be discouraged at the outset. Nothing short of duplication of hospital conditions will justify the enterprises. Among the conditions necessary, the following are absolute essentials:

1 A physician anesthesiologist to assume complete responsibility for selection and administration of the anesthetic and post-anesthetic care.
2 A competent dentist and assistant.
3 An anesthetic machine of the finest type available, permitting the administration of the various gaseous and liquid anesthetics in common use.
4 The best available suction machine.
5 A complete line of oro and nasopharyngeal airways.
6 All accessories necessary for the use of endotrachael anesthesia.
7 Drugs, including the barbiturates, opiates, belladonna derivatives, muscle relaxants, analeptics, vasopressors, and curare antagonists.
8 Needles, syringes, and other materials essential for the administration of intravenous anesthesia.
9 A blood pressure apparatus.
10 Charts and records.
11 A postanesthesia observation room as fully equipped as a comparable room in a hospital.

All that was said regarding preoperative history and examination applies just as strongly here. Each patient must be individually assessed and as complete a preoperative workup performed as possible. If any of the items enumerated are lacking, the procedure must be abandoned. There are no shortcuts and there is no possible excuse for proceeding when to do so would endanger the welfare of the patient.

Each patient comes to the office 1½ hours prior to the start of the anesthetic and receives the proper preanesthetic medication. All patients will receive endotracheal anesthesia which provides maximum safety. Where feasible, the nasal passages, the pharynx, and larynx are sprayed with a topical anesthetic before the anesthetic is administered. Where the patient would prove to be unco-operative, a light plane of surgical anesthesia with intravenous thiopental sodium is first established and then the spraying with the topical anesthetic is performed. In a small percentage of patients, usually young children who are unco-operative, induction of anesthesia is performed with divinyl ether and intravenous anesthesia as rapidly as possible. Once topical anesthesia has been effected and the patient is in a light plane of surgical anesthesia, blind nasal intubation is performed. If this is not successful, nasotracheal intubation is done under direct vision, with or without the use of muscle relaxing drugs. Occasionally it might be necessary to perform orotracheal intubation and there should be no hesitancy in doing so even though it may prove cumbersome to the operating surgeon. Once intubation is effected, maintenance of anesthesia is provided with a mixture of nitrus oxide and oxygen, varying from 80 per cent —20 per cent ratio to 50 per cent —50 per cent ratio. As little intravenous anesthesia as possible is administered once the endotracheal tube is inserted.

At the conclusion of the operation, tracheobronchial toilet is performed, extubation carried out, and the patient transferred to the post-anesthesia observation room. In nearly every instance, return of reflexes must have occurred before transfer to the recovery room. This is important because these patients are expected to go home accompanied by another person within an hour or so. If they are to be driven home, a third person must be in the automobile to protect the patient should a sudden stop of the automobile occur. Once home, the patient is

allowed to ingest liquids only and is put to bed so that complete recovery from the anesthetic is attained with minimal danger. Dependent upon the quantity of the barbiturate administered and the rate of detoxification, this may be a period of several hours.


**SUMMARY**

Anesthetic management for various procedures in dentistry has been presented. Various precautionary measures to make these anesthetic administrations as safe as possible have been described. A method for the safe administration of anesthesia for prolonged procedures in the ambulatory patient has been outlined.



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# The Diagnosis and Management of Rheumatic Fever in Children


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## DIAGNOSIS

RHEUMATIC fever can be diagnosed on the basis of the history, physical findings, or laboratory studies — either alone or in combination.

*HISTORY*:

The most significant single factor is the history of recurrences of beta hemolytic streptococcal sore throat. The patient invariably has a typical story of one sore throat after another, with a relatively poor response to medication. Eventually he has an unusally severe attack of pharyngitis or tonsillitis with a prolonged convalescent period during which time he manifests signs and symptoms of more generalized involvement: fatigue, epistaxis, anorexia, abdominal pain, pallor, weight loss, emotional imbalance, and chest pain. These are subtle signs and symptoms which may or may not finally present themselves clinically as the more severe manifestations of arthritis, carditis, chorea, and erythema annulare.

*PHYSICAL EXAMINATION*:

1. *General Appearance*: The patient often is a fair skinned, delicate featured individual with a pallor all out of proportion to the hemoglobin level. A venous pattern is prominent over the face and trunk. The fingers and toes are spindle-shaped and usually hyperextensible.

2. *Active Carditis*: Tachycardia and a change in the normal rhythm of the cardiac cycle are the most prominent findings. The resting or sleeping pulse commonly exceeds the waking pulse and this single fact can be used to follow the course of cardiac activity. Cardiac enlargement may not manifest itself clinically in the initial attack of rheumatic fever with carditis, although in subsequent attacks it is the rule. Murmurs can be confusing and should not be used as a basis for diagnosing active rheumatic heart disease. However, changing murmurs are significant and should alter prognosis and management of the disease. A friction rub, rumbling heart tones, or fibrillation always indicate a more serious prognosis.

3. *Arthritis*: Hot, swollen, tender, painful joints involving knee, ankle, wrist, elbow, and shoulder are characteristic of rheumatic fever. They are migratory and respond well to salicylates unlike the joint involvement of blood dyscrasia, sickle cell anemia, rheumatoid arthritis, or tuberculous arthritis.

4. *Chorea*: The bizarre involuntary movements of face, trunk, and extremities which


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*Presented before the Joint Meeting of the Section on Pediatrics and the Section on Preventive Medicine and Public Health, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 18, 1955*

disappear during the sleeping hours, unaccompanied by laboratory or clinical evidence of an infectious process and associated with extreme emotional imbalance, are pathognomonic of rheumatic chorea. It rarely is associated with cardiac activity or joint involvement and is more common in children over 8 years of age with a previous history of rheumatic fever. Exaggerated reflexes, hung-up patellar reflexes, silver fork deformity of the hands, and inability to control free flow of speech are characteristic findings.

5. *Skin Manifestations*: Erythema annulare is typically a well-demarcated, reddened skin lesion with slightly raised borders and clearer central areas, occurring on abdomen, chest, and back. These lesions are transitory, lasting several minutes to several hours, and frequently are associated with dermatographia and uncontrollable blushing, which are related to emotional swings and environmental temperature change. The prognostic significance of erythema annulare is equivocal.

Subcutaneous nodules are seen less commonly but usually carry a graver prognosis. These small, hard, pea-sized nodules are located over bony prominences, especially of the spine, scalp, and extensor surfaces of the extremities.

*LABORATORY STUDIES*:

1. *Blood Count*:

A. The hemoglobin usually is between 10-12 grams. However, the clinical impression from skin and mucous membrane color, is that of a much lower level.

B. Rarely is a severe anemia seen except in chronic cases of long duration. The usual range is between 4-4.5 million red blood cells.

C. During the acute phase the total white cell count ranges between 12,000-15,000 with a polymorphonuclear increase. Both of these counts decrease as the disease process subsides.

2. *Erythrocyte Sedimentation Rate*: The sedimentation rate of red blood cells is a nonspecific test for infection, although not specifically, rheumatic fever. In so far as an elevated sedimentation rate usually accompanies activity, the test may be used in evaluating progress except just prior to the stage of congestive failure, when it drops and remains lower or in a normal range. The reason for this has not been satisfactorily explained.

3. *C-Reactive Protein*: In the sera of patients acutely ill with pneumococcal pneumonia, there is a precipitin reaction when the C substance of pneumococci is added. In other acute infectious processes a similar phenomenon occurs due to the presence of an abnormal protein substance which reacts similarly with the pneumococcal C substance. Because of lack of specificity of action, other disease processes must first be ruled out in order to follow the course of activity in rheumatic fever. This test is not influenced by congestive failure but the antirheumatic drugs will affect the results. Upon omission of the drug, however, in the presence of continued activity, the C-reactive protein again reappears.

4. *Antistreptolysin Antibody Titer*: In patients with active rheumatic fever, 95 per cent have a titer of 200 or over; only 42 per cent of patients with inactive rheumatic fever have a titer of 200 or over. In other streptococcal infections, 60 per cent of the patients have a titer over 200. The titer may rise to several thousand but repeated low titers suggests the absence of rheumatic activity or streptococcal infection.

5. *Streptococcal Antihyaluronidase Test*: In streptococcal infections, especially rheumatic fever, a nonspecific heat labile antibody is produced against the hyaluronidase contained in the infecting hemolytic streptococci. The titer is elevated during the acute phase but falls to below normal levels during convalescence.

6. *Electrocardiogram*: Rarely, in the initial attack of rheumatic fever, are any characteristic changes seen on electrocardiographic tracings other than an increased rate. The QT interval may be prolonged in direct proportion to the degree of myocardial damage. Displacement of St-T segments and slight widening of the QRS complexes are seen with myocarditis more commonly then PR prolongation. Stability of the electrocardiogram, despite abnormal changes, is a far better prognostic sign than a changing pattern which might be considered within normal limits.

7. *Cardiac Fluoroscopy*: Cardiac dilatation or hypertrophy may appear in acute rheumatic fever. Early left auricular enlargement can be determined by means of a barium swallow, early in mitral valvulitis. The extreme cardiac enlargement attributed to rheumatic disease is

seen only in subsequent attacks with severe myocardial damage.

8. *Vital Capacity Tests*: One of the first manifestations of myocarditis in rheumatic fever is decreased vital capacity. This test can be done quite simply but because of inexperience or lack of co-operation of the child patient, the results may be equivocal.

## MANAGEMENT

Treatment of rheumatic fever should be divided into three phases: prophylactic, active therapy in the acute phase, and treatment of complications.

*PROPHYLAXIS*:

1. Prevention of hemolytic streptococcal infections may be accomplished by three methods.

A. Sulfadiazine may be given in daily doses of 0.5 gm. in children 8 years of age and 1.0 gm. in older children and adults indefinitely. Reactions of the renal or hematopoietic systems occur during the first six weeks of therapy if they are going to arise.

B. Oral penicillin in doses of 250,000 units daily to all age groups indefinitely. Reactions are minimal, but gastrointestinal complications can occur due to some alteration in the bacterial flora of the intestinal tract.

C. Benzathine penicillin G may be administered intramuscularly in doses of 1,200,000 units to all age groups at intervals of four weeks and continued indefinitely. This is an extremely painful injection and complaints are numerous.

2. Adequate treatment of existing hemolytic streptococcal infections is a must in prevention of rheumatic fever. The dosage schedule recommended by the American Heart Association in a recent communication is:

A. Intramuscular penicillin:
   1. Benzathine penicillin G: One intramuscular injection of 600,000 units to children and 600,000 to 900,000 units to adults.
   2. Procaine penicillin with aluminum monostearate in oil: One intramuscular injection of 300,000 units in children and 600,000 units in adults every third day for three doses.

B. Oral penicillin: 250,000 units three times a day for 10 days, even though the temperature returns to normal and the patient is asymptomatic.

*ACTIVE THERAPY IN THE ACUTE PHASE*:

Pain and fever are the outstanding symptoms and signs of acute rheumatic fever. In spite of numerous innovations in therapy, there is at present no evidence of uniform response or control of the signs and symptoms of acute rheumatic fever, nor is there any evidence to indicate a drug of choice.

Salicylates*: Aspirin has been the drug of choice for generations. It reduces fever; causes a disappearance of joint pain, tenderness, and swelling; eases precordial, muscle, and abdominal pain; lessens the amount of effusion associated with pericarditis; relieves the involuntary movements of chorea; reduces skin manifestations; and alters the numerous laboratory studies such as the sedimentation rate and C-reactive protein, indicating a subsiding infectious process.

The dosage of aspirin which seems to be effective is:

1. First two days: 60 mgm or 1 gr. per pound.
2. Next five days: 40 mg. or 2/3 gr. per pound.
3. Remainder of six week course of therapy: 30 mg. or ½ gr. per pound.

These doses are divided and given at four hour intervals during the first 48 hours and at six hour intervals thereafter. No sodium bicarbonate is given with aspirin. A blood level between 25-30 mg./100 cc. can be accomplished by this dosage and is effective.

ACTH: ACTH, like aspirin, meets all of the requirements of an antirheumatic drug. However, in severe cases in which the disease process is overwhelming or has been present for a long period of time, the adrenal glands may be in a state of dysfunction and are unresponsive to stimulation.

The dosage schedule for ACTH which has been used at LaRabida Sanitarium over the past five years is:

1. First four days: 120 USP Units
2. Next three days: 100 USP Units
3. Second week: 80 USP Units
4. Third week: 60 USP Units
5. Fourth-fifth week: 40 USP Units
6. Sixth week: 20 USP Units

This dosage is given every six hours during

*Dosages recommended by U.K. and U.S. Joint Committee on Rheumatic Fever.

the entire course of therapy. Along with the administration of ACTH, due to the electrolytic imbalance produced, sodium is restricted to 2 gm. daily and potassium chloride is given orally in doses of 2 gm. daily for children under 60 pounds and 3 gm. for over 60 pounds.

Cortisone: Cortisone acts in a fashion similar to aspirin and ACTH in so far as relief of symptoms and signs. With cortisone, the problem of adrenal dysfunction secondary to an overwhelming or long-continued disease process, is not as prominent.

The total daily dosage for cortisone is as follows:

| | |
|---|---|
| 1. First day: | 300 mg. |
| 2. Next four days: | 200 mg. |
| 3. For remainder of first 3 wks: | 100 mgm |
| 4. Fourth-fifth weeks: | 75 mg. |
| 5. Sixth week: | 50 mg. |

*GENERAL CARE*:

1. *Bed Rest*: Clinical experience has shown over the years that irrespective of the antirheumatic drug used, a patient who is unable to accomplish emotional as well as physical rest, does not respond. Whether the patient is cared for in the home or at the hospital is of little importance but rest and relaxation must be achieved.

2. *Diet.* An adequate diet rich in proteins and vitamins, especially B, C and D to supplement antirheumatic therapy is needed. Occasionally iron is needed in long-term illnesses with nutritional deficiency states.

3. *Good Nursing Care*: The person delegated with the responsibility of the daily routine of bathing, feeding, administration of drugs and the quieting of fears and anxieties is by far the most important on the team so necessary for adequate care of the patient with rheumatic fever.

4. *Social Service*: With the vast ramifications of the economic, environmental, and emotional factors in the rheumatic fever patient and his family, there is an unusual opportunity and a great need for the social service worker. Her job is to make the family aware of the problems involved and, in co-operation with the family physician, to set up an educational program concerning the facts of the disease and the importance of routine follow-up studies, prophylaxis, and early treatment of each attack.

5. *Occupational Therapy*: To decrease the trauma of long-term hospitalization and convalescence, an occupational therapist or the mother under guidance, can accomplish much. The patient can be made to feel useful and creative abilities can be developed. The emotional stability encouraged by this program is extremely profitable in the overall picture of therapy.

*TREATMENT OF COMPLICATIONS*:

The major and minor manifestations of rheumatic fever, with the exception of carditis, usually are self-limited and leave no residual. Therefore, the prime concern of the entire therapeutic and prophylactic regimen should be directed at the acute carditis and/or its complications. By far the greatest concern is congestive heart failure. Therapy should include:

1. *Bed Rest*: This is by far the most important single factor in the treatment of heart failure. Emotional and physical activity should be curbed to a level below the cardiac capacity. Bed pans can cause much anxiety and actually produce more activity than bathroom privileges.

2. *Oxygen*: Oxygen is extremely beneficial in patients with acute failure. However, if pulmonary changes are extreme and the medullary centers are narcotized by $CO_2$ retention, the carotid sinus chemoreceptors control respiration. Due to extreme sensitivity if oxygen is administered, the stimulus of hypoxia is lost. the patient becomes apneic, and oxygen must be stopped immediately.

3. *Sedation*: With the exception of digitalis, morphine and the barbiturates are probably the most significant therapeutic agents in relieving pain and anxiety associated with congestive heart failure.

A. Morphine dosage:
   3 yrs — 1/60 gr. every 4-6 hours for pain or extreme restlessness
   5 yrs — 1/50 gr. every 4-6 hours for pain or extreme restlessness
   8 yrs — 1/32 gr. every 4-6 hours for pain or extreme restlessness
   12 yrs — 1/12 gr. every 4-6 hours for pain or extreme restlessness

B. Phenobarbital dosage:
   3 yrs — 1/8 gr. for extreme irritability, three times daily

5 yrs — ¼ gr. for extreme irritability, three times daily

8 yrs — ½ gr. for extreme irritability, three times daily

4. *Digitalis*: The choice of digitalis is on an individual basis but it is wise to become familiar with one oral preparation for daily maintenance and an intravenous preparation for rapid digitalization. For example:

A. Digitalis leaf: digitalizing dose is 0.01 gm./#. ½ of this dose is given stat and the rest is divided into four equal six hour doses. The average maintenance dose for children is 0.01 gm. daily.

B. Digitoxin: digitalization can be accomplished by giving 0.01 mg./# on the same schedule as described for the leaf. The average maintenance dose for children is 0.01 mg. daily.

5. *Diuretics*: Thiomerin®, ammonium chloride, and Diamox® have been used as adjuncts to therapy in congestive heart failure in children. In patients treated with mercurial diuretics for long periods, a hypochloremic alkalosis may develop, which can be readily corrected by the addition of 2-4 grams of ammonium chloride, given in divided doses orally over a period of several days. Three days of ammonium chloride followed by two days of Thiomerin, given in 1 cc. doses subcutaneously, seems to be effective.

Carbonic anhydrous inhibitors such as Diamox given in daily doses of 250-500 mg. are effective and, when given on alternate days, the diuretic effect is comparable.


## SUMMARY

1. The diagnosis and management of rheumatic fever in children has been discussed.

2. The most important single factor in the diagnosis of rheumatic fever from the history is the recurrence of beta hemolytic streptococcal sore throat.

3. Physical examination of the patient with rheumatic fever reveals a fair skinned, delicate featured individual with one or more of the major manifestations of arthritis, carditis, chorea, or the skin manifestations of erythema annulare or erythema nodosum.

4. The majority of laboratory studies used to aid in the diagnosis and management of the patient with rheumatic fever lack specificity of action and should be used only to aid in confirming the clinical diagnosis or impression.

5. Prevention and adequate treatment of the beta hemolytic streptococcal infection are at present the only available means of reducing the incidence of rheumatic fever and rheumatic heart disease.

6. In spite of numerous innovations in therapy, there is no evidence of uniform response or control of the signs and symptoms of acute rheumatic fever nor is there any evidence to indicate a drug of choice.

7. The general care of the patient and the treatment of congestive heart failure as a complication of rheumatic fever are discussed.


«« »»

## A reason for retirement

There is nothing more pitiful than a physician who continues to practice though he is no longer able to keep abreast of the advances in medicine because of the aging processes and disease. It would be better that he be remembered in medicine for the physician he was, rather than a doddering old man who continually gets into trouble and who is rendering a poor quality of service to his patients. This comes to some earlier than to others, so that age is no criterion. *Clarence K. Elliott, M.D. How to Retire. Nebraska M. J. July 1955.*

# Management and Rehabilitation of the Bedridden Patient

**David I. Abramson, M.D., Professor of Physical Medicine and Rehabilitation and Head of the Department, Moderator.**
**Maxwell D. Flank, M.D., Clinical Assistant Professor of Physical Medicine and Rehabilitation.**
**Mrs. Carol H. Preucil, Associate Professor and Head of the Department of Medical Social Work.**
**Harold M. Visotsky, M.D., Clinical Instructor in Psychiatry.**

*Dr. Samter*: The subject for today's Seminar has been suggested by our residents who feel the need for orientation in the management of the bedridden patient. It is a pleasure to welcome Dr. Abramson back to the Seminars in his new role as Chairman of the Department of Physical Medicine and Rehabilitation — this seems quite a departure from his last Seminar on "Cold Injury to the Extremities."

*Dr. Abramson*: Thank you, Dr. Samter. I would like to preface the panel discussion with a few general remarks. As you know, although most hospitals are set up for the care of acute illnesses, more or less, they are plagued by the demands of the long-term patient. The needs of the long-term patient, the theories of his rehabilitation, are well understood. Yet, one wonders whether our social institutions are responding adequately to the needs. The problem is important, since there is little doubt that the physical care and the social well-being of long-term patients require as much attention as the phase of active medical treatment.

Despite intense efforts, most general hospitals find that they treat a fairly large group of patients for a period of thirty days or more, even though the medical condition of many of these individuals may no longer require occupancy of a general hospital bed. In part, this unfortunate situation is due to the fact that alternative facilities, such as nursing or convalescent homes, are frequently unavailable or overcrowded. Even so, however, the awareness of the problem and a concerted effort on the part of physicians, particularly those on the house staff, to utilize all means to rehabilitate a patient and make him as self-sufficient and independent as possible under the circumstances could alleviate much unneccessary suffering and expense. Through neglect of readily available technical knowledge of medical rehabilitation, we are creating disabilities that need not exist.

Allow me to cite an example of mismanagement of rehabilitation of a patient from the files our own Hospital. A woman, 72 years of age, was in the hospital for the treatment of an anemia of unknown origin. A splenectomy was performed and the patient was discharged two weeks later. She was then re-admitted three days afterward because she had developed a sub-diaphragmatic abscess. She had a stormy clinical course and was at complete bed rest for eight weeks. At the end of this period, she was discharged into out-patient care. Without any preliminary attempt at physical training, she was placed in a wheelchair. When she tried to walk, she was unable to stand by herself, became pale and clammy, and "faint" and dyspneic, all signs of severe deconditioning. At this point, and only then, the physical therapist was called in to rehabilitate her. The initial phase took another week, and at the end of this period the patient was barely able to get out of bed by herself and

**SEMINAR**
**of the**
**DEPARTMENT OF MEDICINE**
**of the**
**UNIVERSITY OF ILLINOIS**
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walk to the bathroom. She had by no means regained her normal endurance to physical effort. It seems pertinent to emphasize that this patient remained in the hospital for a week longer than would have been necessary if a program of rehabilitation had been set up at the proper time.

Before discussing a specific approach to the problem, it is essential to define the term "bedridden patient." In the past, it has been applied to patients with progressive mechanical difficulty, such as the hemiplegic, the paraplegic, or the patient with multiple sclerosis or rheumatoid arthritis. In a general sense, one can extend and broaden this concept to include all patients who are at bed rest, as for example, a patient with myocardial infarction, congestive heart failure or blood dyscrasias.

It is my impression that residents and interns in the Department of Medicine would like to utilize facilities for rehabilitation of their patients, but they are not certain about the mechanics of the program. Obviously, the decision to initiate rehabilitation is the physician's responsibility. He should decide when the physical state of the patient permits a gradual preparation for active exercise and ambulation. At all times, a contact must be maintained between the physician in charge of the patient and the physiatrist and physical therapist. In addition, the psychiatrist and the medical social worker have an important role in rehabilitation. In other words, there should be an inter-departmental team, working jointly. We have here a group of members of such a team.

First, I should like to ask Dr. Flank, who is a physiatrist, what approach and what techniques he would utilize in the rehabilitation of a bedridden patient, who has been immobilized for four to six weeks.

*Dr. Flank*: It might be best to use a specific condition, myocardial infarction, to outline the procedures which we use at the U. S. Veterans Hospital, Hines, Illinois. At first, the patient is kept at complete bed rest except for the use of a commode if his condition permits. During this time, he is interviewed by the staff of the Physical Medicine and Rehabilitation Service. During the second week, he is given active exercises, including breathing exercises, flexion and extension of the toes, dorsiflexion and plantar flexion of the ankles, and extension and flexion of the wrists. In the beginning, these exercises are repeated five times, twice a day, but then they are increased to ten times, twice a day. Gradually the severity of the exercises is increased, so that by the third week isometric contractions of the gluteal muscles and active movements of the shoulder and hip are being performed. During the fourth week, active movements of the shoulder, hips and knees are attempted in a sitting position. At the end of the fourth week, the patient walks for one to five minutes, with rest periods. Bathroom privileges are also given to him. In the fifth week, the walking is gradually increased so that by the fourth day of the fifth week, the patient is walking about 300 yards twice a day and is sitting up in a chair in his room for one-half hour twice a day. During the sixth week, he begins stair climbing in preparation for returning to his home.

It is necessary to point out that the rehabilitation program is initiated by the Physical Medicine and Rehabilitation Service only upon request of the resident on the service in charge of the patient. At all times during the program, the patient is under the close observation of the "team". If the physical therapist in the course of the treatment notices abnormal responses, such as a rapid rise in pulse rate, dyspnea on exertion, or the onset of pain in the chest or arm, the exercises are stopped and the resident in cardiology is notified. Upon his decision, it is either discontinued or carried out at a slower pace.

*Dr. Ronald Fox,* Resident in Medicine: Do you have a program of work classification?

*Dr. Flank*: As I have mentioned, in the sixth week, the patient is permitted to walk up the stairs. He it then placed on graded activity in the Occupational Therapy Clinic, and an attempt is made there to evaluate him for future work assignments.

*Dr. Walter Wood,* Resident in Medicine: I am not clear at which point the patient begins to ambulate.

*Dr. Flank*: We do not ambulate the patients until the fourth week after the acute attack of myocardial infarction. We are well aware that some authors advocate chair therapy, but we are still conservative in our program of the rehabilitation of the cardiac patient.

*Mrs. Ann Maly,* Physical Therapist, Department of Physical Medicine and Rehabilitation: How does the age of the patient affect the rehabilitation program?

*Dr. Flank*: The age is not important since the exercises are not strenuous.

*Dr. Abramson*: The program that Dr. Flank has described, although designed for patients with myocardial infarction, can be utilized with some modifications in the treatment of a patient with congestive heart failure who has undergone a protracted but successful course of treatment. In fact, it can be applied to any type of patient who has been at bed rest for any period of time and who has no mechanical disabilities.

Physical rehabilitation is only one part of the job. Equally important is the treatment of psychic trauma associated with a chronic illness and a long period of bed rest. I should like to ask Dr. Visotsky, a psychiatrist, how he would handle the anxiety that almost inevitably develops in the bedridden patient, and how he would counteract the defenses which are built up in response to this situation. Not infrequently, as you know, a bedridden patient becomes wedded to his state and considerable difficulty may be encountered in breaking up the bonds that exist in his mind.

*Dr. Visotsky*: Anxiety is a feeling of apprehension and uncertainty. When associated with organic illness, we must determine the scope and dimensions of this anxiety.

First, what does the illness mean to the patient? In our society where the emphasis is placed on the individual's ability to remain independent, the illness may be a serious blow. What does the illness mean in determining the patient's role in the family? How does the illness affect his economic and social positions? Much of this information can be obtained from the patient and from his family.

Knowing the patient's reactions to his illness, one can then deal with underlying fears. Strong social pressures operating to suppress feelings of dependency may be cancelled by giving the patient permission to be dependent in his illness; this will help, for instance, some cardiac patients who have a need to deny the severity or even the existence of the illness.

Patients who, on the other hand, "enjoy" their illness and show much anxiety and little tendency to get well may profit from an interpretation of their needs to remain sick. It is important to be honest and consistent with the patient at all times.

*Dr. Abramson*: Do you imply that it might be necessary to frighten the patient?

*Dr. Visotsky*: Emphatically not. I believe that a patient can be informed as to the nature and prognosis of his illness in a non-threatening manner.

*Dr. Samter*: Do you have a simple method for estimating the patient's reaction to his illness?

*Dr. Visotsky*: No, there is no simple method. Caution and repeated contact will provide us with adequate answers.

*Dr. Abramson*: Can probing be dangerous?

*Dr. Visotsky*: One does not have to probe to elicit information. Relative facts can be obtained through the medium of conversation.

*Dr. Buford Hall,* Assistant Professor of Medicine: Would you care to make any specific statement on the depression which often follows myocardial infarction?

*Dr. Visotsky*: A post-myocardial depression, which is frequently seen, is still a depression. It must be handled supportively with much care given to understanding the reason for this depression. There is much to understand in terms of the patient's concept of himself, as for example, how he and his body have been depreciated by the illness. Many patients feel guilty in being ill, running up medical bills, and contributing nothing to the support of their family. The future looks bleak and the role they are to play seems empty. The psychiatrist can handle this most effectively by being able to define clearly the part the patient can take in his family life and in society. It ought to be stated, by the way, that it is just as important to tell a patient what he can do as well as what he cannot do. There is usually too much emphasis on the latter aspect.

*Dr. Abramson*: The gap between theory and practice in the rehabilitation of the bedridden patient is most intensely felt by the Social Service worker who is unable to find a place for the patient either in his home or in the community. I would like to ask Mrs. Preucil to outline some of her problems.

*Mrs. Preucil*: The social worker can make a real contribution to the rehabilitation of the bed-

ridden patient. The exact nature of this contribution and its relative significance in the total program vary in individual situations. There are, however, certain functions which are appropriately carried on by the social worker in any case where rehabilitation is needed.

Since certain social factors in the patient's life may be relevant in his participation in, and reaction to, rehabilitation, information on these is often pertinent. Important among these factors are: the cultural background of the patient, his role within the family group, the family's status in the community, and the attitudes of the family and community toward the patient and his handicap. Also, highly significant is the patient's and his family's response to his diagnosis and the limitations which it imposes. The social worker is well equipped to obtain such information and to evaluate it in the light of the particular medical situation. It is his responsibility to share pertinent information and his interpretation of it with the other members of the medical team.

A simple example of the importance of the knowledge of social factors is that of a woman patient for whom every evidence in the clinical picture indicated that an active rehabilitation program was advisable. In this instance, however, the patient came from a culture in which "women are supposed to be taken care of." Until there was recognition and consideration of this philosophy and some attempt to deal with it, the patient, her family, and the community in which she lived could not accept any program which would lead to the patient's becoming an independently functioning individual.

Another function of the social worker is the attempt to understand the patient's concept of himself and to help him to find a positive motivation for rehabilitation. The patient may readily agree to the proposed program and appear willing to carry it through; yet, as he discusses his feelings about his handicap and about the possibilities for rehabilitation with the social worker, his anxieties may come to the surface. He may doubt his adequacy as an individual, his capacity to undergo rehabilitation, his acceptance by his family or peers even after rehabilitation — each of these doubts may make him hesitant of becoming involved in the program which he seemed to accept when it was first presented to him. The nature of this relationship and of the social worker's skill in relaxing the patient so that he will discuss some of his problems might afford opportunities for more intimate contact than those accomplished by other members of the medical team.

Closely related to this function is the one of helping the patient to set reasonable goals for himself within the realities of his social situation. An example of this is the young man with an extreme cardiac disability who could see as the goal of rehabilitation only employment in his previous job or one equally hazardous for him.

Often the social worker is the only one who can confront the medical team with the realities of the social situation and the limitations which these may impose upon the patient's rehabilitation As this information is combined with that of the psychiatrist and the other medical personnel it is important that it be evaluated by the total medical team in order to establish a rehabiliation program which will be realistic for the particular patient and yet be as near the ideal as possible.

If rehabilitation is to be successful, the patient must be included in the planning. All too often planning which has been done *for* a patient does not have the results which seem justified by its apparent soundness. Unfortunately, what the patient thinks is best for him and how he sees that this might be carried out are sometimes not identical with the medical team's ideas in these areas. Assurance that the patient and his family are included in the planning is the responsibility of the social worker as well as of other members of the team.

In order to be useful, the social worker's evaluation of the social situation should be made as soon as possible after the diagnosis has been established. If the planning and program for rehabilitation extend to the patient's life after discharge from the hospital, as they would in most cases, early planning necessitates a knowledge and understanding of the part played by the family and the community in the patient's ability to adjust at home.

Perhaps the function which is most frequently assigned to the social worker is the task of finding the community resources which can meet the patient's needs most effectively at home or in an institution. A corollary of this

is the responsibility of the worker to help the patient and his family use these resources to best advantage. If the only resources which seem available are ones which are unacceptable within the patient's group — such as public assistance for certain individuals or care other than by the family in its own home — the benefits of extensive and expensive hospital care may be jeopardized; for, the patient will not follow through with the program after discharge.

Actually, part of the responsibility of the social worker is the instruction of the patient and his family in the art of coping with and, perhaps, changing any adverse attitudes which may interfere with acceptance of a sound rehabilitation program. In working with other members of the medical team, the social worker may well find it appropriate to suggest changes in the timing of the various steps to be taken in order that the patient can accept the program more easily. Occasionally, the patient will feel free to make a suggestion to the social worker on some aspect of it, whereas he might not feel as free to disagree with one of the members of the team who was more intimately concerned with the supervision of the physical program during his hospitalization. Although such a suggestion may be of little or no value, the worker should share it with the other members of the team in order that every possible way of obtaining the patient's essential participation may be exploited.

In review, the social worker's function might be summarized as: bringing pertinent social data to the medical team and interpreting these in the light of the particular medical and rehabilitation problem; participating with the other members of the medical team in the evaluation of the social factors in the total picture; learning the patient's idea of his potential and helping him to set reasonable goals for himself; and finding the most appropriate community resources and helping the patient to use these to best advantage.

*Dr. Visotsky*: It would appear at this point that the patient is being over-interviewed. Actually, most of the information should and can be obtained by the physician in his initial contact with the patient. An understanding of the emotional components of a severe disabling illness is important. The internist when aware of these factors can obtain much information and insight into the patient's needs.

*Dr. Abramson*: Dr. Visotsky's last remarks make one wonder whether the existence of a team, as elaborate as ours, is not an unrealistic approach to the problem of rehabilitation. Although necessary in a university hospital, where a clear separation of each of the phases of rehabilitation is part of the teaching program, its application to smaller hospitals may not be practical, except, perhaps, in a modified form. Many of the techniques which are useful in preventing deconditioning are generally simple and frequently can be performed by the nurse on the ward, provided she has been so instructed. Certainly, such an approach should reduce the incidence of decubitus and contractures of the joints. I am quite certain — and I would like to add this as a final thought — that a good family physician, who has been a friend and advisor of the patient for many years, and is well trained in the principles of both medicine and rehabilitation, combines in his own person many of the advantages and, in fact, avoids some of the problems of communication, of the "team."

# A Program of Respiratory Rehabilitation for Asthma and Emphysema

Audrey Evans DeRango, R.P.T., Chicago

FAULTY breathing habits are often a major source of disability in asthmatic and emphysematous patients. The inefficient breathing pattern is not a result of the asthma itself, but rather, develops out of the patient's reaction to his condition. Breathing habits can, therefore, be corrected through re-educating the patient to use a more effective respiratory pattern.

Breathing exercises have been used quite extensively in England for nearly thirty years. It is only in recent years, however, that attention in this country has been directed toward the use of physical exercise for asthma and emphysema.

It is the purpose of this paper to describe the program of therapeutic exercises used at the University of Illinois Research and Educational Hospitals as an adjunct in the treatment of patients with asthma and emphysema. Further studies which attempt to evaluate these techniques are currently in progress. The aims of this exercise program include the following:

1. To decrease the severity of attacks by instructing the patient to relax and focus his attention upon expiration.

2. To decrease dependency upon his nebulizer as the fear of attacks becomes less.

3. To increase the activities the patient can tolerate without shortness of breath.

4. To improve posture through liberating neck and shoulder muscles from the respiratory pattern.

5. To decrease pain and fatigue in accessory respiratory muscles.

6. To decrease the accumulation of secretions, thus reducing the dead space in the lungs and minimizing coughing.

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*Presented before the Section on Allergy, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1955.*

*Physiologic Considerations.* — Breathing, usually unconscious, is more fully under voluntary control than most body functions, since most respiratory muscles are striated. Thus breathing exercises are not dissimilar to those directed at other muscle groups. Through suitable muscle re-education, rate, depth and rhythm of respiration can be altered.

In quiet respiration, inspiration is the active phase carried out primarily by the contraction of the diaphragm and to a lesser extent by lateral expansion of the rib cage. Expiration is almost entirely a passive process caused by the elasticity of the lungs and the rise of the diaphragm to its dome-shaped position when relaxed.

During forced inspiration, e.g. after strenuous exercises, the diaphragm is still the most important muscle and accounts for about 60 per cent of inspiration. Contraction of the external intercostal muscles increases the anterior-posterior and lateral diameters of the thorax and provides most of the remaining 40 per cent. Accessory muscles of respiration, the neck and shoulder muscles, are also used to increase further the amount of air inspired by raising and expanding the rib cage, but add only little to the volume inhaled.

While quiet expiration does not require muscular activity, forced expiration uses another group of accessory muscles which compresses the rib cage and abdomen expelling the air similar to the action of bellows. Bending forward will thus aid forced expiration.

Rate, depth and rhythm of respiration are strongly influenced by emotional states. Patients with respiratory impairment are generally tense and anxious, thus further restricting their respiration.

It is characteristic of asthmatics during an attack to neglect the use of the diaphragm and the lateral movements of the lower ribs and, instead, to expend their efforts using accessory

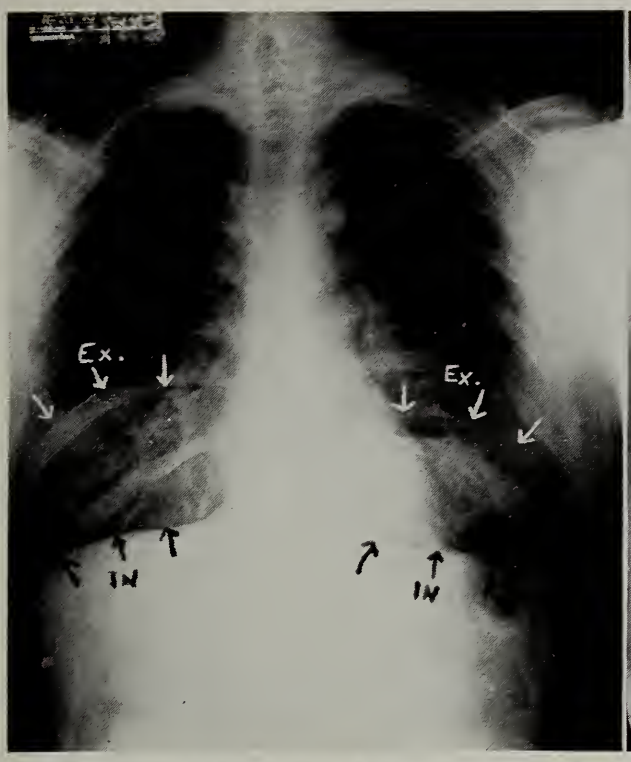



**Figure 1. Double exposure x-ray of a normal subject showing diaphagmatic excursion of 8.5 cm. on the left and 7.0 cm. on the right.**

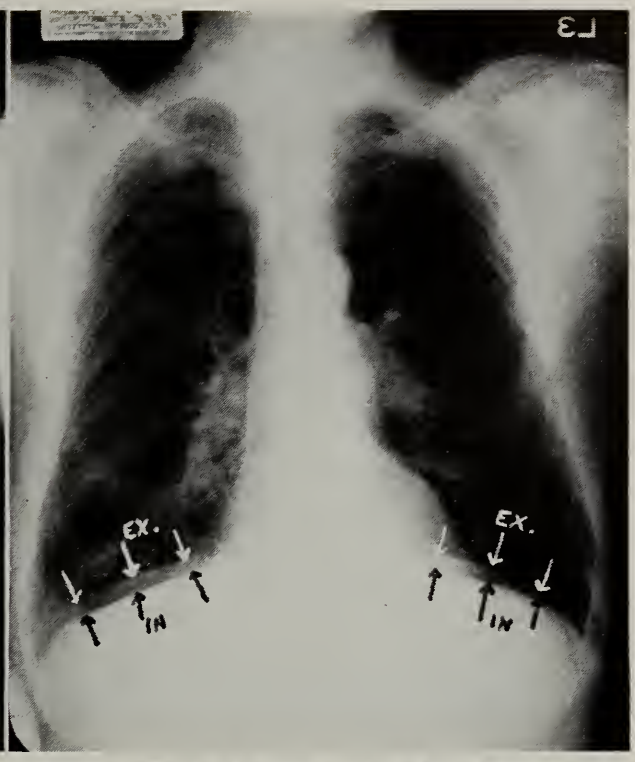



**Figure 2. X-ray showing the characteristic loss of diaphragmatic excursion in a 57 year old patient with a 12 year history of bronchial asthma.**

muscles of inspiration. Patients when short of breath tend to rush the next inspiration before they have completed the previous expiration. As a result of this premature inspiration, the lungs become more and more enlarged, and excursion becomes limited by the fact that inspiration begins with the already inflated lung. Some patients actually relax the diaphragm so that it rises, instead of descending, during inspiration.

A comparison (Figures 1 and 2) reveals how little the typical chest breather uses his diaphragm even in deep breathing. Using a double exposure technique, X-rays taken at the height of inspiration and at the depth of expiration illustrate the differences in the response of a normal subject with that of a 57 year old patient with a long history of bronchial asthma.

Patients acquire the habit of using accessory muscles of respiration (sternocleidomastoid, external intercostal, pectoralis minor, scaleni, serratus anterior, rhomboid, trapezius) during attacks and then gradually carry over this faulty respiratory pattern for breathing between attacks as well. This erroneous use of accessory muscles which accounts for the typical neck and upper chest breathing pattern in asthma, produces persistent pain and tension in these muscles. Using neck and shoulder muscles for respiration is responsible for the equally common complaint of inability to engage in activities which require elevating the arms such as painting or hanging clothes. The typical posture with hunched shoulders, forward projecting head, and a compensatory "sway back" results from the habitual use of these muscles in breathing.

The respiratory exercises are designed to break the chest breathing habits of the patient and retrain him to use his diaphragm, abdominal muscles and lower rib cage muscles. The success of respiratory re-education is dependent largely on his co-operation and understanding of the program. It is, therefore, imperative that the patient be given a clear and simple explanation of normal and abnormal respiration. He must be made to realize that faulty breathing is not part of his disease, but the result of his reaction to his illness, and that this abnormality can be corrected. In all of the breathing exercises the emphasis is on improving expiration, and the patient must understand why this is necessary. The time spent in so orienting him reduces the period required for teaching him the breathing exercises.

Most individuals who suffer respiratory dis-

tress are anxious and apprehensive and hence are refractory to re-training of the breathing pattern. Consequently relaxation techniques are an integral part of the respiratory training program. It has been our experience that the emphasis of somatic relaxation of muscle groups as described by Jacobson[13] is the most promising approach, particularly in patients whose responses are complicated by severe emotional reaction to the respiratory disorder itself.

*Techniques Of Breathing Exercises.*

Breathing exercises are divided into elementary and advanced phases. The elementary phase is adaptable to group therapy which facilitates the integration of the patient into the adventure of respiratory breathing. Group therapy, however, should be supplemented by individual instruction to adjust exercises to individual needs. The first periods are devoted to rhythmic diaphragmatic breathing. The patient lies on his back in a quiet room and his head and knees are comfortably supported with pillows. His chest and abdomen are visible.

*Exercise* 1: *Elementary Diaphragmatic Breathing* (*Figure* 3)

1. The patient is instructed to place one hand on his upper thoracic and neck regions and the other hand on the upper abdomen.

2. The muscles of the chest and neck should remain relaxed throughout the respiratory cycle.

3. The patient inspires with minimum motion of the rib cage, the upper abdomen "swelling" beneath his hand as the diaphragm descends.

4. The upper abdomen should be drawn in as the patient exhales audibly, making an "f" or "s" sound through his teeth.

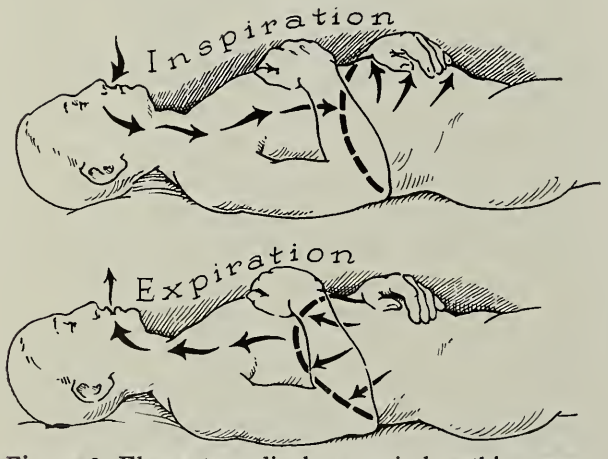



**Figure 3. Elementary diaphragmatic breathing exercise.**

5. When the patient understands the exercise, he should be allowed to practice unobserved.

6. The patient should now be instructed to increase the period of expiration and this should be timed. He may start with an expiration that lasts five to ten seconds and should be encouraged to double or even triple the expiration time.

7. If it becomes necessary for the patient to take a gasping breath accompanied by a sudden rise of the bony thorax, he has extended his expiration beyond his capacity. Cough and an increase in wheezing may occur during exercises, but should not discourage their continued use.

*Exercise* 2: *Increasing Lower Rib Cage Mobility Using a Belt.* (*Figure* 4)

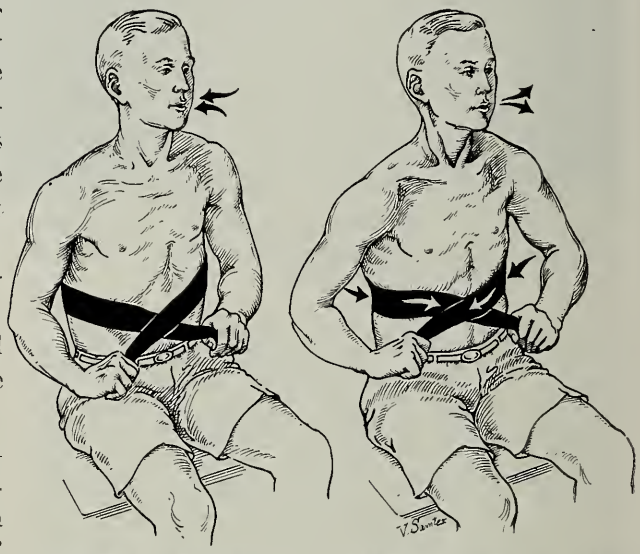


**Figure 4. Exercise for increasing lower rib cage mobility using a belt.**

1. The patient places a 2-4" belt around the lower part of the rib cage.

2. The belt crosses in front of the patient as he holds an end of it in each hand.

3. The patient is instructed to tighten the belt thus compressing his ribs as he exhales through his mouth.

4. At the end of expiration the patient relaxes the tension in the belt allowing the lower ribs to expand as he inhales.

5. When the patient understands the exercise he should be encouraged to perform it rhythmically 15-18 times a minute. He should rest at intervals to avoid hyperventilation and arm fatigue.

*Exercise* 3: *Side Bending.*

1. The patient sits on a stool or an armless chair and places his right hand over the side of

the lower left ribs. The left arm is relaxed.

2. The patient slowly bends toward his left side compressing the ribs with his hand as he exhales maximally.

3. The patient relaxes his hand and returns to the upright position as he inhales.

4. After six rhythmic bends to the left the patient repeats the same exercise to the right side.

*Exercise* 4: *Forward Bending.*

1. The patient sits on a firm stool or chair.

2. The patient relaxes his shoulders, arms, and neck, he bends forward from the waist as he exhales.

3. As the patient returns to the upright position he is instructed to inhale slowly and effortlessly.

4. The patient repeats the exercise six times rhythmically.

*Exercise* 5 *Arm Elevation*

1. The patient sits holding a barbell or weighted broomstick in his hands.

2. The patient is instructed to raise the barbell as he inhales, thus employing the shoulder muscles and restricting their use as accessories to inspiration.

3. As the patient lowers the barbell he exhales by contracting his abdomen and lower ribs.

4. The weight of the object is increased as the patient improves.

The patient should be instructed to use diaphragmatic breathing consciously during ten minutes of every hour until this pattern becomes automatic. After this, he may continue every morning before arising, every evening before going to sleep, and at other times during the day when respiratory distress is present. It is important that he be encouraged to practice the simple exercises for the rest of his life even during asymptomatic intervals. It has been the experience of several investigators that exercises maintained during periods of freedom from bronchial asthma are most likely to produce permanent improvement in the shape of the chest and the vital capacity.

In order to maintain clinical improvement the patient should advance to the following functional activities:

1. He should attempt chopping and pumping motions with his arms which are synchronized with his diaphragmatic breathing.
2. He should learn to climb stairs at a regular rhythm: two to four with expiration, one to two with inspiration. The instructor should note the number of steps climbed without dyspnea. The record represents a simple and fairly objective measure of progress.
3. He should blow balloons since this provides a good resistive exercise for the advanced patient. The program should then be extended systematically to include the performance of all of the so-called skills of daily living.

*Posture Training*: Postural training is an important part of the respiratory re-education program. Figure 5 shows the forward projection of the head, protracted shoulders and compensatory lordosis typical of the chest breathers referred for respiratory training classes. The following exercises are those found most effective in improving this abnormal posture:



**Figure 5. Typical posture of chest breathers showing forward projection of the head, protracted shoulders and compensatory lordosis.**

*Exercise 1*: *Upper Abdominal Strengthening.*

1. The patient rests in supine position on a firm surface with knees somewhat bent.
2. The instructor places his hand beneath the patient's back in the lumbar region.
3. With his arms extended, the patient should slowly raise his trunk ten inches from the supporting surface. He should then slowly return to the supine position. Exercise of this type will increase the strength of the upper abdominal muscles.

*Exercise 2*: *Lower Abdominal Strengthening.*

1. Patient lies supine on a firm surface.
2. The patient is instructed to flex his knees to his chest with arms extended at his side.
3. The patient attempts to lift his hips off the supporting surface.
4. The patient maintains the knees flexed between hip lifts and repeats the exercise 5-8 times.

*Exercise 3*: *Back Extension.*

1. The patient lies prone on a firm surface, with his arms extended at his sides.
2. The patient is instructed to pull his scapulae together (retract) and then lift his head and shoulders without using his arms for assistance.

The above exercise should be preceded by simple instructions aimed at improving postural alignment with particular attention directed at reducing the obliquity of the pelvis through sustained contraction of the abdominal muscles. The patient is instructed to hold the chin in. The patient must "get the feel" of standing correctly.

*Postural Drainage*: Postural drainage constitutes a simple and effective method of aiding the lungs to expel the secretions which are so abundant in asthma, bronchiectasis and emphysema. Since man spends most of his time in the upright position and generally uses at least one pillow when reclining, bronchial secretions accumulate at the bases of the lungs which are farthest from their natural outlet. The cough reflex functions in the larynx, trachea and primary bronchi, but decreases rapidly beyond the latter so that there is a high degree of tolerance to the presence of pus and secretions in the distal portion of the bronchial system. Consequently these secretions collect there.

There are several methods of employing postural drainage. The method of choice is governed by the patient's tolerance. Most patients find the following technique very effective (Figure 6):

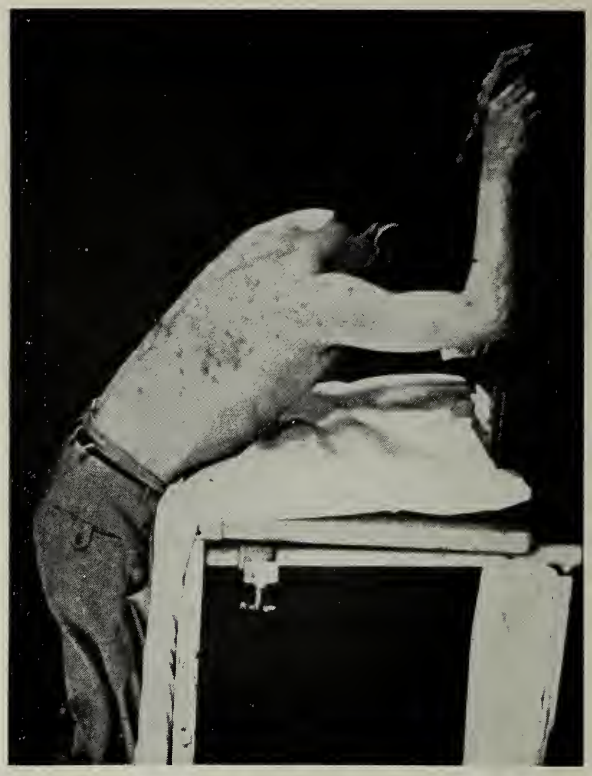


**Figure 6. Postural drainage position from the movie "A Program for the Respiratory Rehabilitation of Asthma and Emphysema."**

1. The patient is instructed to lie over the edge of the bed so that his trunk is flexed downward approximately to a 45 degree angle. To insure comfort and provide support, the patient rests his elbows on a low stool. This position is well tolerated and may be maintained for increasing periods, the duration of drainage depending on the condition of the patient.
2. The patient's chest is percussed while he is in the postural drainage position. This further facilitates drainage by helping to loosen adherent secretions.
3. The patient is encouraged to twist his trunk slowly while he is in the postural drainage position. This will often, but not always, promote additional expectoration.
4. Generally four five minute periods are utilized with one to two minute rest periods between. The patient is instructed to cough once each minute while he is in the head-downward position.

Another method which requires no equipment

is the knee-chest position described below:

1. Patent assumes the kneeling position.
2. With his knees flexed at 90°, the patient acutely bends from the waist and rests on his elbows.
3. To avoid fatigue the patient should return to the kneeling position to rest after 3-5 minutes. Rest periods should be short to prevent secretions returning to the bases of the lungs.
4. Raising first one shoulder and then the other to give each lung in turn more opportunity to drain, the patient continues in the above position for 15-20 minutes.

The sudden change into the head-downward position is sometimes distressing to adults, and with acutely ill patients it is usually impractical. In such cases elevating the foot of the bed 18 inches, which results in a 14½ degree angle incline is an effective means of facilitating drainage. Asthmatic children benefit from hanging inverted on a monkey bar or trapeze for short periods each morning. Most of them enjoy this type of activity.

## SUMMARY

A program of therapeutic exercises for patients with asthma and emphysema has been presented. The chronic, relapsing and complex nature of these diseases makes it difficult to give a statistical estimate of improvement. Nevertheless the preliminary evaluation of the results obtained with ventilatory re-education shows promise.

*Acknowledgment*

The author is indebted to Dr. Max Samter and Dr. David L. Abramson for advice and assistance in the preparation of this manuscript and to Dr. Edwin Liebner for interpretation of X-ray studies on the emphysematous patients.

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# Educational Therapy for Mental Hospitals

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AS AN introduction to the subject it seems most appropriate to quote this passage from the Scriptures:

"My people are destroyed by the lack of knowledge;
Because thou hast rejected knowledge
I will also reject thee . . . ."

Hosea 4:6

Although re-education is currently spoken of in psychotherapy, education as such, does not enjoy much vogue as a factor in the maintenance of psychic homeostasis. It can be observed, for example, that presumably well educated persons not too rarely succumb to both minor and major mental disorders. But we cannot cast any of our formulations in the mold of the absolute. In mental disorders, we deal with the results of many forces. Education cannot be thought of as the summation of facts and figures but rather as the significance of facts in relation to each other, and in relation to patterns which are the foundation of attitudes, and an orientation to all those broad aspects of living which make for good psychic balance.

We are all aware of the protean character of reality. The practical psychological task for man is to erect a reality and frame of reference which will be most serviceable and yield the maximum of happiness and satisfaction. In the fortunes of the psyche there are many things which can upset its economy. It is almost a truism that every individual has a psychic as well as a physical tendo Achillis. To one man, status may be so important that any serious reversal in that respect is enough to precipitate serious mental disturbance; to another it is wealth, power, or love. This by no means exhausts the possibilities for psychic morbidity. The personality may and does frequently adopt goals in the pursuit of which a mistaken life plan may be generated which will contradict and clash with real, attainable goals. But excluding all more or less specific causes for emotional and mental disturbances, we may find that the weakness of the matrix and texture of the personality expose it to disruption and collapse upon impact with subliminal forces. If it is poverty-stricken, if it is of poor quality and weak texture, the probable consequences are a weak ego, a faulty sense of reality, and an unserviceable frame of reference.

Some data already exist to suggest a correlation between poverty of the personality and the incidence of the more severe psychic disorders. Redlich, et al[1] have derived some evidence to show a relatively high incidence of psychoneuroses in the upper socio-economic levels, but psychosis significantly higher in the lower socio-economic levels. It would seem justifiable to suggest that a contributing factor to the incidence of psychoses in the lower brackets might be deficiencies in educational and cultural influences.

But education, in the sense of biological and psychological conditioning is not the mere summation of facts and figures, although as part of the amalgam it constitutes, factual data usually can be extracted from it in considerable quantity. Neither is education a time interval spent in designated halls of learning, which interval is formally certified to by designated persons and institutions.

Education in its true and biological significance means the acquisition of a broad perspective of the surrounding world, leading to adequate attitudes and beliefs. It imparts a sense of relationship of man to man and to the universe he inhabits. It encompasses mature judgment in the light of abiding values. It is one

*Presented before the Physicians' Association of the Department of Public Welfare, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

means by which emotional maturity is acquired; also emotional stability, which is not founded upon insensitivity but rather is the fruit of a profound appreciation of the human scene, its significances, and connotations.

Have we swung so far in psychotherapy in our preoccupation with the manipulation of instinctual drives and effects as to lose sight of and generate a contempt for the role of conditioning and education in the maintenance of psychic homeostasis? Freud did not entirely lose sight of it when he voiced his hopes for the "future primacy of the intellect" in man's motives and behavior.

The contempt for pedagogy as an instrument of therapy is unwarranted on still other grounds. It is not difficult to demonstrate that what happens in the class of the skillful pedagogue is something more than mere exposition, and it should be recalled that it is often said of a professor or instructor, "he certainly knows his stuff, but he just can't teach." For it cannot be denied that what occurs in the class of the skillful pedagogue is a process akin to the transference of psychotherapy. The process of learning is not merely one of passive absorption, for its most powerful implement is motivation and the most successful teacher consciously or unconsciously comes to employ it through the transference relationship.

Even from a more or less technical point of view the close relationship between education and therapy is evident. It has been expressed by J.W. Powell[2] in the following:

"Education and therapy are complementary phases of a single process—the *learning* process as directed to the achievement of effective maturity. The extent of their identity has been obscured by their more salient differences in emphasis; the one upon mastery in the handling of *judgments,* the other in the handling of *feelings.* By an oversimplified aphorism, we could say that education teaches the individual how to examine *what he thinks* about what he feels important; therapy to examine *how he feels* about what he thinks important . . ."

This relationship of education and therapy was apparently keenly sensed by L. C. Marsh[3] whose observations on this point were forcibly expressed in these words:

"The mental patient should be regarded not as a patient but as a student who has received a 'condition' in the great subject of civilization as most of us understand it, and psychiatry should thus approach him with an intent to re-educate rather than with an intent to treat . . ."

"I still object to calling a community of mental patients a hospital or organizing it as such, for the accent is then on the medical phase, and this phase should not, in my opinion, be accented. A community of mental patients is preeminently an educational-social-industrial community and should have on its staff members expert from these fields, as well as physicians. While there is much medical work to be done for mental patients it must be evident that the education-social-industrial challenge is a far greater one. I suggest the erection, for experimental purposes at least, of one institution based on this conception."

It should be remembered that a great many patients in state mental hospitals come from socio-economic strata of society where motivation for learning is of a poor order. Their experiences have often been miseducative, and not rarely one notices a resistance to what education truly constitutes. Poorly conditioned as they are to the processes of education, one can often surmise how much of the world has escaped them even by the very poor reading ability which so many evidence. The ineptitude in this function often is so intense, the simplest words offer great difficulty. With many of these persons it seems like a conservative guess that the function of reading was rarely exercised. This in itself, as far as the purveying of information is concerned, may be amply compensated for in modern times, since the many modern means of communication may make up the deficit. Even those who run may gather the news. What cannot be replaced is the particular atmosphere that more leisurely and more calmly perused material confers.

Judging from mental hospital patients, reading, both as recreation and as education, would seem almost a dying art. Plenty of reading material is at hand but the trend is toward digest and postage-sized periodicals, which creates the impression that reading, with a large section of the population, is a kind of necessary evil to be disposed of in the least time-consuming and

most casual manner. Whatever significance such trends may have for our culture it is certain that a large proportion of the state mental hospital's population seems only one step ahead of illiteracy. Their prehospital careers have apparently supplied them with little or no incentive for reading, learning, and enlarging the boundaries of their awareness. The old idyl of the child or even the adult curled up beside a fireplace and immersed in the reading of a good book has lost much of its vividness and appeal. We might speculate that the decline of reading other than comic books, newspapers, and digests may have something to do with the decline in the vividness of imagination and feeling for poetry.

Be that as it may, it does not seem unreasonable to believe that reading and the greater appreciation of the significance of various phenomena in the human scene enriches the consciousness and enlarges ego boundaries. It should also help in increasing ego strength. Experience in group psychotherapy seems to demonstrate to what extent the natural intellectual curiosity of the child has been dulled and dampened in adults, and especially in the institutionalized patients. Sometimes their reactions seem to suggest that because somewhere in their previous training and experience they had come to invest the processes of education with extreme artificiality and affectation, or that it was so forbidding and remote from everyday concerns, they had more or less completely avoided them.

Approached from the vantage point of the proper and specific contexts of current concerns, it may be discovered how the natural intellectual curiosity begins to revive. For example, in group psychotherapy sessions the discussion reaches the point where the group talks about the origins of life, what it is, and what maintains it. The therapist quite naturally draws on his store of biological knowledge. He talks about and illustrates the structure of cells, their metabolism and reproduction, and since a clinical laboratory is available he takes the group on tour to the laboratory and demonstrates a variety of blood and tissue cells under the microscope to these patients. Patients examine the slides under the microscope with awe, ask questions, and inspect other apparatus.

At present, at least one Illinois state hospital is planning to have classes in typing and shorthand. Apparently it is easier to recognize the utilitarian values of this training but subjects with far broader implications are not yet seen to have any connection with therapy.

The institution itself, in its various activities, constitutes a distinct miniature society. It contains enough of the elements of social problems to supply the material for a whole curriculum of studies. We might call it a kind of indigenous education which, sufficiently digested and absorbed, is a prototype and paradigm of the functional education sometimes sought after by educators. The teaching of Latin, Greek, and other subjects of a cultural trend of the past undoubtedly has its value, but cannot be brought into functional relationship with the problems of everyday living. The kind of education which may prove effective will arise from the needs of the situation. It is possible that, as a result of the institution of patients' courts and government, which has been done by the Boston Psychopathic Hospital, a desire might arise to get better acquainted with jurisprudence and legal practices. This might require some study of legal principles. If the patients' courts likewise adjudicate disputes in hours and wages, this might require study of labor-management relations and that may be the basis of another course of study. Whenever interest is developed on the part of a sufficient number of patients, which gives rise to a desire for a systematic study of the subject, a class can be formed and as far as possible integrated with the activity that gave rise to the demand.

But there is a great need for teaching the three R's. A considerable number of individuals may be prevented from achieving advancement on their jobs by lack of a high school diploma. Attaining a high school education makes such person better equipped for advancement as a result of his hospitalization. The educational program may provide regular accredited curricula for those who have not completed primary or secondary schools. In a few institutions it is actually being done. Marcy State Hospital in New York is an example. Certainly it would appear that there is no good reason to allow the patients' minds to lie fallow the entire duration of the hospital stay.

All the foregoing would also hold true for the arts. Thus classes in painting, sculpture,

dramatics, and music may be formed. Such contemplated programs would seem to add hugely to the budgetary requirements of an institution. Even so, the program could still be defended on grounds of economy, for it may be hoped that the discharge rate would increase, with consequent relief from overcrowding and the necessity for creating ever more space. But the program could be so operated as to add little to the total cost. It would provide just the right kind of opportunities for volunteer services.

One aspect usually insufficiently explored is the use of patients themselves in therapeutic ventures and this would provide a two-edged therapy — therapy for the patient-instructor, and therapy for the instructed. Most mental hospitals can count on a sprinkling of college graduates with good residual capacity. When the necessity arose during the war, and the institutions were badly undermanned, in some hospitals patients served as attendants on open wards and rendered an excellent account of themselves. Among the attendant corps it is common knowledge that these patients render a service superior to some of the average paid employee-attendants. The conception of patient education here stated seems visionary and radical because we are so accustomed to regard patients in the framework of the "asylum". It takes re-orientation to see the patient from the standpoint of rehabilitation and personality restructuring.

Our best efforts even under the most ideal conditions will not yield 100 per cent results. Initially, the percentage of more or less complete social rehabilitation may not be drastically altered. There may still be a considerable residue of regressed denizens of the back wards whose potential ceiling appear quite low. But even here, a sense of the dignity of man must dictate the aim of keeping personality functioning at the highest possible level. But we can conclude with confidence that in the long run the discharge and recovery rates will show a significant increase over institutions with a more static regimen.

An atmosphere vibrant with purposefulness and intellectual exploration is bound to exercise a profound attraction on individuals who might otherwise be averse from such considerations. In such an atmosphere the social pull on the individual in the direction of some achievement and social status, according to cultural and intellectual criteria, would be irresistible; and it need not be reiterated that they are powerful incentives. It may be contended, as a result of these projected means or techniques, the patient may leave the hospital in a much sounder state of integration, with greater ego strength and intellectual and emotional perspective than he ever possessed.

The immediate results of these programs may appear disappointing. Moreover, the metamorphosis of any hospital into the kind of institution contemplated here will be long and arduous. It will have to be persisted in for a long time before it bears its best fruit, and always the goals must be clearly kept in sight. However, the time will come when they are well established, and then the techniques and traditions of the institutions will exert their full force. We must see in this program, interaction between the institution and society at large. If this regimen becomes better known by the public in general, its acceptance by patients and their anticipations of its benefits will increase its effectiveness.

In searching for motives and incentives to form a nidus about which personality structuring can crystallize and which at the same time is a source of energy for the process, the pursuit of the fine arts stand out as preeminently effective. If the arts grow out of the current activities, the activities germane to the hospital's operation, they are then most logically motivated. For example, scene painting and decoration for the plays, pageants, presented by the patients, puppet making and manipulation, and playwriting. The satisfaction to the ego which patients who participate in a play enjoy can be deduced from watching the glow which lights up their faces and seeing the meaningful and purposeful energy with which the enterprise is approached. If the patient has been sufficiently stimulated to embark on the pursuit of an art totally unrelated to the hospital's occupations and solely for its own intrinsic values, it will serve the same purpose and should receive comparable encouragement. All of it leads to a perspective of the individual in society in relation to his fellows and helps to generate and revive the energies and social interests which make for the desired adjustment.

For example, a patient in an institution has a flair for music. He has a good voice and has taken the lead role in several operettas performed by the patients. He composes and has written several musical plays for presentation. He takes another fellow, dull to borderline intelligence with psychosis, under his wing and teaches him singing. To watch this pupil, to see his eyes light up with a new, unaccustomed glow when he speaks about his singing is to realize that a very deep-seated recuperative process has been tapped. He is finding a new focus in life, a new meaning. He comes to his doctor asking rather imperiously, "Doctor, I want you to come and hear me sing," and his request indicates the discovery of a newly found source of mental energy. One may discover the same thing in every other art. Puppet-making and playing may lead logically to a study of the drama and the theater arts. Publication of an institutional magazine should lead to an interest in journalism and the graphic arts. Book reviews will make him further acquainted with the broader fields of literature.

These pursuits are not the sharp focus of psychotherapy but any considered opinion will find that they facilitate it. The same may be said of the various occupational therapies. There may be intrinsic value in such occupations as rug-weaving, toy-making and sewing, but where some occupation germane to the patients' activities in the hospital intrigues a patient it would appear in the long run preferable to allow him to pursue his bent and not to attempt to force him into a stereotyped activity simply because it is labeled "occupational therapy". Where the patient manifests no choice one may exert gentle pressure to bring him into some activity that will occupy him and revive his human social interest. If this task is sufficiently accomplished so that he is brought into the current of the hospital's activities, it will have served is purpose.


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## Hypertensive therapy

Of four basic hypotensive drugs or their derivatives, 38 preparations in more than a dozen colors and shades have come to my attention. This count does not include dosage forms, sirups, or parenteral preparations. Eleven of these are combinations of two drugs; five are combined with a third less specific drug. Equally colorful brochures and advertisements present the manufacturers' attractive claims for the various drugs, which may be listed as a composite therapeutic triumph: tranquilizing and sedative, without danger, tolerance, or side-effects; for the average case, the most effective single hypotensive agent available, significant blood pressure reduction in 80 per cent; potent long acting, will enable the physician to manage 90 per cent of his cases; for hypertension, angina pectoris, nervousness, and psychoses, *Robert Sterling Palmer, M.D. Essential Hypertension: A Selected Review and Commentary. New England J. Med. June 2, 1955.*

# Banthine (Methantheline Bromide) as a Premedication Drug in Pediatric Anesthesia

**Luke Tajima, M.D., Chicago**

BANTHINE® (B-diethyl-aminoethyl xanthene-9-carboxylate methobromide) is a unique atropine-like substitute used in the therapy of peptic ulcer[1]. Banthine derives most of its unique pharmacological properties from its chemical structure, the quarternary amine structure, which suggests autonomic ganglion blocking property.

In small doses its predominant action is one of a parasympathetic neuro-effector blockade; that is, it has an atropine-like effect on the postganglionic nerve endings of the parasympathetic nervous system. When used in moderate doses it resembles the pharmacological effect of the tetraethyl ammonium compounds; that is, a blockade results of all autonomic ganglia, the sympathetic as well as the parasympathetic nervous systems. Thus Banthine acts simultaneously on the paraympathetic and the sympathetic nervous systems. When used in large nonlethal doses it exerts a reversible curare-like action on the skeletal muscle.[2, 3]

During chronic tolerance studies, some of the side actions noted were blurring of vision, xerostomia, and inability to void in the presence of prostatic hypertrophy because of the relaxation of the smooth muscle of the bladder[1]. One of these side effects, xerostomia, was utilized to study the effect of Banthine as an antisialogogue premedication for general anesthesia. It has been used in conjunction with procaine amide and its anti-sialogogue potency is reported to be far superior to that of atropine.[4]

As an antisialogogue the dosage of Banthine was 1 mg. per year of age for children between 1 and 10 years administered parenterally[4]. This working dosage scale approximates the dosage range of 0.2 to 0.4 mg. per kilogram of body weight which was found to be pharmacologically active by studies on man[1].

Chronic tolerance studies on rats and dogs with Banthine showed a wide margin of safety between the pharmacological dose and the $LD_{50}$[5]. Sensitivity, toxicity, and dosage have been studied in children, infants, and newborns. The study showed a wide margin of safety between the pharmacological dose and the dosages causing early signs of toxicity such as fever, dryness, flush, mydriasis, tachycardia, and vomiting. These signs are similar to those of atropine intoxication[6].

## METHOD OF STUDY

This present study of Banthine as an antisialogogue was done over a six months period with 100 children between the ages of 1 and 10. It was the sole premedicating drug used and the open drop method of induction with vinyl ether and ethyl ether and maintenance of anesthesia with ethyl ether was employed. Tonsillectomy, adenoidectomy, and circumcision were the principal types of surgery. Banthine was used in two concentrations: as a 5 mg. per milliliter solution and as a 10 mg. per milliliter solution. Normal saline was used as the diluent of Banthine powder. The more dilute solution was used in younger children for easier and more accurate administration. Since Banthine is an ester which hydrolyzes slowly, the solution was changed every two weeks. Banthine solution was given parenterally, either intramuscularly one-half hour preoperatively or subcutaneously one hour preoperatively.

## RESULTS

Two factors prior to induction and during induction were noted: the presence of any signs of toxicity and the amount of salivation during induction. In 9 of the 100 cases flush was detected but in only 3 was it marked. There was no appreciable mucous secretions in 89 cases; 8 cases had slight quantity; and 3 cases, a moderate quantity prior to and during induction. The last 3 cases received their premedication intramuscularly about two hours prior to surgery. This is a relatively high incidence of lack of undesirable secretions in inductions with the open drop method and although no comparable series was studied with adequate doses of atro-

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pine, the clinical impression gained after the study with Banthine as an antisialogogue is that it appears to be a potent drying agent, probably more so than atropine.

Postoperatively there were no cases of fever or inability to urinate in the 100 cases. All the posttonsillectomy and postcircumcision cases were sent home the day of surgery. The incidence of postoperative nausea and emesis, though difficult to evaluate, was made simpler since only one nurse was in charge of the posttonsillectomy and postcircumcision room. The impression was that the incidence of postoperative vomiting was less in the children premedicated with Banthine than otherwise as indicated by the linen changes.

## DISCUSSION

This antisialogogue property of Banthine is enhanced and brought about by means of two mechanisms of action: the drug is predominantly a parasympathetic depressant in small doses and acts through a postganglionic blockade; in moderate doses, it blocks the ganglion cells of both the parasympathetic and sympathetic nervous systems. Thus Banthine in moderate doses acts doubly on the parasympathetic nervous system. at the ganglion and the postganglion. The dosages used in this study were from 0.1 to 0.4 mg. per kilogram body weight and constitute small and moderate dosages.

The use of the open drop method of induction and maintenance with ethyl ether as the primary anesthetic agent in the nonsedated child provides the most severe test for any antisialogogue. Therefore, this study was conducted with nonsedated children undergoing general anesthesia predominantly for tonsillectomy, adenoidectomy, and circumcision and utilizing the open drop method of anesthesia.

The working dosage scale of 1 mg. per year approximated the 0.2 to 0.4 mg. per kilogram pharmacological dosage range in the average child. However, in younger children the dosage computed on the age basis falls below the 0.2 mg. per kilogram dose. Therefore, for children of 1 to 2 years of age and for children who appear markedly lighter or heavier than other children of their respective ages, dosage should be computed according to weight. Toxicity studies mentioned elsewhere in this paper revealed that infants of 4, 6, and 8 weeks of age could tolerate Banthine dosage of magnitudes such as 6 and 12.5 mg. parenterally for several doses[6], whereas such amounts would have been given to 6 and 10 year olds in this present study. Thus this wide tolerance range indicates the drug is relatively safe.

Banthine given subcutaneously seemed to afford a wider range of effective time than that given intramuscularly. However, when given by the latter route, its effect has been noted frequently within 10 minutes and in almost all cases within 15 minutes, but the duration of effectiveness appears to wane after one hour and almost certainly after 1½ hours.

Subcutaneously, Banthine is effective within 20 minutes and lasts almost two hours. The intramuscular route probably is preferred when there is only a short time for preparation for surgery such as in emergencies. Banthine solution may be kept at room temperature for two to three weeks without loss of activity.

The loss of reflex inhibition properties of atropine when Banthine is substituted was not evaluated in this study. However, some studies have been made showing that Banthine possesses reflex inhibiting property[7].

## SUMMARY

A study of the antisialogogue effect of Banthine a quarternary amine with ganglionic blocking properties and postganglionic atropine-like effect, in 100 children between the ages of 1 and 10 years is presented. Minimal, negligible toxic effects were noted. Rapidity of onset by the intramuscular route and excellent drying effect for the appropriate length of time were observed.

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# The Father of Chicago Medicine

LESTER R. DRAGSTEDT, M.D., CHICAGO

THE state of medicine in any large city is a composite of the work, the abilities and the ideals of many men both within and out of the medical profession itself. It is determined by the unselfishness and generosity of its leading citizens, the character of its educational institutions, the contributions of chemists, physicists, and of other scientists, as well as the ability and devotion of the practitioners of medicine. Forty years ago when I made known my desire to study medicine, the doctor in the small western town where I was born remarked, "So — you will go to Boston, Philadelphia, Baltimore or Chicago." At the time I was a little surprised that these particular cities should be singled out above many others in the United States, but even today it is probably true that the present high position of American medicine in the world is due chiefly to the contributions of these centers. How did Chicago come to occupy such an enviable position as a leader in medical education, practice and research? Wealth and a philanthropic spirit in its citizens are not sufficient. Detroit and Pittsburgh, to name only two great cities, have had no dearth of these but have nevertheless remained deserts both with respect to medical institutions and outstanding physicians. Chicago, however, has produced many men whose names are known wherever scientific medicine is discussed. Among these are usually listed the names of Daniel Brainerd, Nicholas Senn, John B. Murphy, Arthur Dean Bevan, L. L. McArthur, Frank Billings, N. S. Davis, Bertram Sippy, James B. Herrick, Ludvig Hektoen, A. J. Carlson, H. G. Wells, D. B. Phemister, and many others.

Frank Billings was for many years the most eminent medical figure in Chicago, and perhaps also in the nation. No physician in Chicago was so successful in commanding the respect and affection of the medical profession and of the city's most important citizens. Professor of Medicine and Dean of Rush Medical College, Dr. Billings by his dominant personality, unselfish spirit, and ability was the leading force in medical education. Largely through his personal efforts the clinical departments of medicine and surgery were established at the University of Chicago. In discussing the work of Dr. Billings, the following revealing incident of his student days was related to me by Dr. D. E. Clough of Glendale, California who returned to Chicago in June, 1952 to attend the 50th anniversary of his graduation from Rush Medical College. Dr. Billings was just about to begin his Clinic for the Junior and Senior medical students in the amphitheater of the old Rush Medical College building on West Harrison Street. About 150 students were present, including visiting physicians, for Dr. Billings was an impressive and popular teacher. As he came forward and grasped the lectern preliminary to making a few remarks about the patient that was to be presented, student Clough sitting in the front row arose and said, "Dr. Billings, tell us something about the last illness of Dr. Fenger." Dr. Billings looked earnestly at the questioner, then at the students, removed his gold-rimmed, old fashioned, angular spectacles, and with tears in his eyes said, "Not today, gentlemen, not today. All that I am or ever expect to be in life I owe to Christian Fenger."

In April, 1932 the American Society for Clinical Surgery held its annual spring meeting at the Mayo Clinic in Rochester, Minnesota. After the scientific sessions were over, Dr. Will Mayo invited the Society for a pleasure cruise on his yacht on the upper Mississippi. Some thirty-five visiting surgeons, together with Drs. Will and Charles Mayo made up the party. In the afternoon while most of the guests were outside on the deck enjoying the scenery provided by the bluffs of the upper Mississippi, Drs. Will and Charles having passed this way many times before, were sitting by themselves in a stateroom. Dr. Will beckoned to me to come over and sit with them. "You are not interested

*Read before the Society of Medical History of Chicago, November 10, 1954.*

in our beautiful Minnesota scenery?" he inquired. "Yes," I replied, "but I am more interested in this opportunity to converse with you. Would you be willing to tell me who the medical teachers were who had the greatest influence in shaping your careers as surgeons and medical administrators?"

As was his habitual custom, Dr. Charles looked up to his older brother, Will, as if to pass the question on to him. Dr. Will looked out of the window for some little time, and then spoke with deep conviction.

"We owe a lot to Drs. Mikulicz of Prague and Joseph Price of Philadelphia. However, the man who taught us most, and who was chiefly responsible for our development in medicine was one of your fellow townsmen."

I looked at Dr. Will Mayo for a moment, and then said, "Could it be Dr. Christian Fenger."

"Yes," he said, "Christian Fenger was the greatest teacher we ever had, and the greatest influence in the development of our method of practice."

One evening not many years ago at a meeting of The Chicago Literary Club, I had an opportunity to speak with Dr. James B. Herrick. In response to my question as to who of his teachers had exerted the greatest influence in his development, Dr. Herrick without hesitation replied, "Christian Fenger. Fenger taught all of us. He taught John B. Murphy, Nicholas Senn, A. J. Ochsner, Dean Lewis, Ludvig Hektoen, and L. L. McArthur. He taught all of us. He brought scientific medicine to Chicago. He was an excellent pathologist. He was a surgeon, too, but my God, how slow he was and how clumsy! He knew his stuff, though, but he was not a good speaker. He had a low mumbling voice and his words were often lost in his whiskers, but what came through was well worth listening to."

Dr. Ludvig Hektoen acknowledged the contribution of his teacher in a somewhat different vein. "The fundamental function of medicine is research. Research is the base of all its activities. The treatment of disease and injury, the education and training of physicians, the education of the public, all are based on the knowledge created by research as compounded of experience, observation, and experiment. Fenger's great service was that he illustrated and exemplified more than anyone else of his day in this center, the mighty significance of research in medicine. He made the best use he could of the opportunities he had to advance the understanding of disease, its diagnosis and treatment. In his writings the word research was used seldom, but the spirit of research prevailed in all his work as pathologist, teacher, surgeon, and consultant."

Christian Fenger was born in Breininggaard, Denmark on November 3, 1840. His father was a landowner in moderate circumstances. There were twelve children in the family, and, as Christian says, his father worked hard to give nearly all of his seven sons an opportunity to study. Love of the natural sciences prompted Christian to begin advanced studies at the Polytechnical School with the intention of becoming a civil engineer, but after a year he yielded to his father's wishes and began the study of medicine. During this period he earned a part of his expenses by teaching in high school and later by giving instruction to medical students in anatomy, and by coaching students of dentistry for their examinations.

The medical faculty of the University of Copenhagen at this time was of excellent quality, and Panum, the physiologist; Schmidt, the anatomist; Reisz, in pathology; and Mathias, Saxtorph, and Buntzen, in surgery were among the best in Europe. War between Denmark and Prussia interrupted Fenger's medical education and he served for a year as Assistant Surgeon in the Augustenborg Hospital under the Physician in Chief, Professor Studsgaard, whom he always afterward thought of with admiration and friendship. Following his graduation in 1867, he worked for two years as an assistant in the clinic of Hans Wilhelm Meyer and took part in Meyer's celebrated investigations on adenoid vegetations in the nasal pharynx. From 1869 to 1871, Dr. Fenger served a two-year internship in surgery at the Royal Fredericks Hospital in Copenhagen, although his appointment to this position had been opposed by Professor Saxtorph, Chief of the Surgical Division, because Fenger had previously worked with the German, Meyer. In reference to the situation Fenger said, "During the two years that I served as intern not a word was spoken between Professor Saxtorph

and me." It is possible that this enmity may have played an important role in Fenger's subsequent career. During his internship Fenger wrote an essay on certain bone operations which was accepted by the University, and at the same time conducted experiments on gunshot wounds of horses at the Royal Veterinary College and constructed instruments for the purpose of finding bullets in the tissues and removing them. The publication of his paper entitled, "Concerning the Endoscopy of Gunshot Wounds," led to a grant from the Royal Danish Ministry of War, which permitted him to take part in the Franco-Prussian War of 1871, under the auspices of an international ambulance service led by Professor Socin of Basel, Switzerland. After the Franco-Prussian War, Fenger went to Vienna where he studied pathological anatomy and surgery, coming under the influence of the great surgeon. Theodor Billroth and the famous pathologist, Rokitansky. On his return to Denmark, he was appointed Prosector to the City Hospital in Copenhagen, where he worked for four years and had an opportunity to study pathology and conduct many post-mortem examinations. During this time he wrote an article on cancer of the stomach in which he described his extensive studies on the growth of cancer cells in the wall of the stomach and extending along the nerve fibers and blood vessels. This study of cancer of the stomach was an important contribution and one of the first attempts to account for the pain characteristic of this disease. He also made studies on the kidney and the heart, and wrote papers which were marked by accurate observation and clear, orderly analysis of the problems raised.

In 1875, during the illness of Rasmussen, Professor of Pathological Anatomy, Fenger was appointed a docent in the University and took over the instruction of students in pathology. Following the death of Professor Rasmussen, the chair of pathological anatomy became vacant and Fenger prepared to take part in the competition for this position, but to his surprise, and contrary to the usual custom, the place was given to Professor Carle Lange without competition. Although interested in surgery, the antagonism of Professor Saxtorph prevented Fenger from securing a position in the surgical department and, consequently, feeling that his road to an academic career in Denmark was blocked, he decided to go abroad in order, as he said, to reach an independent position more rapidly. With the aid of borrowed money Christian went to Egypt where his brother, Dr. Sophus Fenger, had preceded him and had entered upon the practice of medicine in Alexandria. Christian took over his brother's practice when the latter returned to Denmark to be married, and subsequently went on to Cairo where he secured a salaried position as a District Physician under Dr. Bay, Chief of Medical Affairs in that city. While in Cairo, Fenger investigated Egyptian eye disease (trachoma) in the children in the public schools and made a report about it to the government. He also made investigations of a highly fatal epidemic disease of the respiratory organs in horses and mules, and his published report revealed a remarkably thorough study of this disease. He regarded the disease as infectious, supposing the poison to enter the respiratory tract in the air. He recommended that healthy horses be protected by covering the head with a mask of cotton treated with a solution of carbolic acid and then dried, and that the diseased horses be carefully isolated from the normal animals. These reports indicate that Fenger was well aware of the new bacteriology developing in the wards and laboratories of Pasteur, Lister, and their contemporaries.

Fenger was investigating bilharziasis in a large military hospital when he developed dysentery, followed by inflammation of the liver. He recovered but when the disease recurred, the following year, Fenger decided to leave Egypt and go to a temperate climate. He states that in Cairo he had been a physician for a part of the American colony and among them certain American officers whom the pasha had brought in in order to reform the Egyptian Army. The wife of one of these officers, who came from Bloomington, Illinois, assured Dr. Fenger that dysentery was unknown in that city, and that a doctor of his ability could make a good living there. Fenger resigned his position in June, 1877 and traveled by ship from Alexandria to Liverpool, and thence to New York. When he arrived in Chicago his funds were practically exhausted and acting on the advice of a countryman, Dr. S. D. Jacobsen, who told him that he might as well locate in Chicago as any other place, Fenger decided to stay.

General practice in a small office over a saloon on Green and Indiana streets, in the Scandinavian settlement, supplied a meager living and enabled Fenger to begin his acquaintance with the medical men of Chicago. He immediately recognized that his colleagues had no knowledge of the pathology and physiology with which Fenger had become so thoroughly conversant as a teacher in Copenhagen, and accordingly he looked for an opportunity to teach these sciences. In the spring of 1878, he secured a position as physician to the Cook County Hospital, where he began to give lectures and demonstrations in pathological anatomy, a science which, as he states, was entirely unknown to the physicians there. At that time, the County Commissioners of Chicago were perhaps the most corrupt in its history and one thousand dollars was the price medical men were required to pay for an appointment on the hospital staff. It was reported that Fenger was able to make this payment as a result of money he received from the sale of a mummy he had brought with him from Egypt. Doubtless, the purchaser of this mummy was the father of the genial exhibitor of Old Timer, so delightfully described by our fellow-member, Mr. Shilton, some years ago.

A revealing account of Dr. Fenger's first work in the County Hospital was given by Dr. L. L. McArthur, one of Chicago's leading surgeons, then a student at Rush Medical College.

"As a newcomer and with few friends, Dr. Fenger was given for his clinic the inconvenient hour from 1:00 to 2:00 p.m., an hour never before assigned to an attending man for a clinic. 12:00 to 2:00 p.m. in all previous years was set aside for luncheon, rest, and recreation. Following custom, the students failed, at first, to attend in any large numbers. Thus it happened that Dr. J. B. Murphy and myself, fascinated by Fenger's wonderful techniques in making a post-mortem examination, thrilled by the revelations each necropsy offered, and rewarded by his efforts to convey to us the information that should have gone to the entire class, were constant attendants during these first months, one taking down the findings, the other sewing up the cadaver. Undoubtedly this experience remained ever after a potent factor in J. B. Murphy's future development, as was later true of so many others. Fenger quickly saw and accepted the importance of surgical antisepsis and asepsis. In this he was a pioneer. The introduction of Listerian methods in the County Hospital through the influence of Christian Fenger caused me physical pain, for I was the junior to whom was delegated the dressing of every open wound or sore. Thus, in the hospital all of the leg ulcers, inflamed ingrowing toenails, felons, etc. must be dressed under a spray of 5% phenol, washed with 2½% phenol, covered with eight layers of gauze, one layer of mackintosh and a ninth layer of gauze outside, a useless layer. This meant dressings from 8:00 a.m. to 6:00 p.m. daily and no trained nurses. But soon there began to be healings per primam shown at first with pride to the staff and interns, and later as something to be expected; finally, if the desired result was not obtained, it was a reproach to someone."

"After the first two years as pathologist at Cook County Hospital Fenger had so thoroughly impressed the staff with his familiarity with surgical problems, that the members of the surgical staff left him in charge of the services during vacations. With these opportunities for surgical demonstrations, appointment as attending surgeon soon followed, and for fourteen years he was actively engaged with every kind of surgical problem. During all these years he constantly accumulated specimens of every type of surgical pathology."

Concerning Chirstian Fenger and this period, Ludvig Hektoen wrote, "He was part and parcel, the very influence of a definite period of Chicago pathology and surgery. There will never be another Christian Fenger, not because a similar person may not appear, but because the period in which Fenger lived and worked will not be dupliated. Surgery, an ancient but somewhat limited art, was changed practically within his generation into a potent and progressive branch of medicine. He made important additions to surgical science in the face of heavy burdens and laborious ways of working. Think for a moment of the labor and time spent on surgical operations in homes even in the latter part of the horse and buggy era. Major operations were performed in private houses of every sort and there was no such thing as a properly equipped operating room in any hospital in Chicago.

The lack of medical libraries in Chicago, un-

til well toward the end of Fenger's life, was a serious obstacle to his scientific work. Nevertheless, he carried on literary and investigative work almost from the start. He did his reading and writing at home and provided himself with books and periodicals he most needed. After his death, the collection of some six thousand items was given to Rush Medical College. In clinical lectures and demonstrations he reviewed the topics under consideration with much greater completeness and detail than was the custom of his colleagues. He liked to trace the growth of knowledge on a given subject. While his speech was halting and subject to any interruptions, stenographic reports of his lectures would reveal a beautifully clear and orderly presentation. He never relied overmuch on his own knowledge, but spent long hours in the night preparing his clinics. His writings all bear the stamp of the thorough scholar with a logical clear-thinking mind. His style is direct and vigorous.

With his special knowledge and interest it was inevitable that Fenger should remain closely associated with medical schools and hospitals during his entire career. In 1880, he was appointed curator of the Museum at Rush Medical College, and in 1884 was made Professor of Surgery in the College of Physicians and Surgeons, and Surgeon in Chief at the Passavant Hospital and the German Hospital when these two were founded. In 1893 he became Professor of Surgery in the Chicago Medical College, later to become the Northwestern University Medical School, and Chief Surgeon at Mercy Hospital. In 1899, he left Northwestern to become Professor of Surgery in Rush Medical College and attending surgeon in the Presbyterian Hospital.

In 1900, on his 60th birthday, a testimonial banquet was given for Dr. Fenger and attended by 500 physicians, made up largely of former pupils and friends from the Chicago area and all parts of the United States. He was presented with a loving cup on which was engraved his portrait and an inscription from the American Medical Association. Nicholas Senn presented him with an album containing autographs of those present at the banquet, and the following year he was honored by the King of Denmark with the Order of Knight of Dannebrog. In the later years of his life, Dr. Fenger was often depressed and thought some of returning to Denmark to spend his old age. The testimonial dinner and the fine demonstration of appreciation by the men of his profession, however, affected him deeply and on returning from the dinner he said to his wife, "We won't go back to Denmark. I shall live and die in America."

After his return from a trip to California, in the late winter of 1902, Dr. Fenger was stricken by pneumonia and died at his home in Chicago on March 7. His request that a post-mortem be performed was complied with and this revealed, in addition to pneumonia, evidences of healed tuberculosis of the lungs and gallstones.

During his twenty-five years in Chicago, Fenger wrote many papers which were published in the surgical and pathological journals of his adopted country. After his death they were collected and republished forming two large volumes. When read with the knowledge of the present day these papers are not impressive and cannot account for the extraordinary influence that Fenger exerted. They are not to be compared with the scholarly and historical writings of William Stewart Halsted of the Johns Hopkins Medical School and yet the impression that Fenger made upon his students and colleagues rivaled that of his eastern contemporary. Perhaps the explanation is best given in the words of James B. Herrick, former president of this Club, and one of the greatest of Chicago's medical men, in his book *Memories of Eighty Years.*

"The two Chicago surgeons who for many years were most widely known in this country and abroad were Nicholas Senn and John B. Murphy, both of whom by the way always acknowledge their indebtedness to Christian Fenger. They were great teachers and practitioners of surgery as well as investigators. Why did Senn and Murphy leave as successors no group that can justly be called the Senn or the Murphy School? Why was it that Fenger left what is often referred to as the Fenger group of pathologists, surgeons, and physicians? Senn and Murphy were eagerly listened to by thousands of students and practitioners—by many more in fact, than heard Christian Fenger. Doctors still tell of the lessons they learned from Senn's dramatic amphitheater clinics, or Murphy's Socratic method of teaching. But there was something lacking in these two, a something that Dr. Fenger possessed. It is difficult to ex-

press it in one word. Was it not largely humility, effacement of self, a sincere effort to work not for the sake of personal glory but to help the other man."

Today, after more than 40 years, at the mention of his name my heart again responds with a quickened beat and my eye grows misty. Again I see before me the simple, plain man with his kindly smile and cordial greeting. In memory he is still the great, the learned, the wise surgeon, beloved not because he was a super-human but very human being, a man who, as John Buchan said of another, was greater than any of his achievements. His personality was in itself his greatest achievement."

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## Arterial graphs

A study of arterial injuries and subsequent amputation in World War II in which ligation of the involved artery was the accepted form of treatment, serves as a good control for the treatment of these injuries by other methods. With simple ligation, for example, the incidence of amputation following wounding of the brachial artery was 26 per cent, femoral artery 53.2 per cent, and popliteal artery 72.5 per cent. Newer techniques now permit a more successful approach. Not only is lost blood replaced and bleeding controlled, but the arterial channel itself is preserved thus saving limb as well as life. In approximately 75 cases of arterial injury this had been accomplished in most instances by primary repair of the patient's injured artery. In 10 patients, homografts were required to bridge the defect in extensive arterial wounds. There were three brachial, six femoral, and one radial injury in this group. All grafts were patent at the time of discharge of the patients, and have continued to function in all but one. This graft became occluded more than a year after operation, after a good collateral blood flow had developed and at this time continued to have palpable but diminished pedal pulses. This patient has intermittent claudication but no patient in whom a graft was inserted has had an amputation. *E Stanley Crawford, M.D. et al. Use of Arterial Homografts in 90 Peripheral Arterial Lesions. Texas J. Med. Oct. 1955.*

## Meat, potatoes and vegetables

In food, vitamin B12 usually is associated with animal protein; it has been detected in only one or two vegetable foods such as groundnuts. Vegetarians, even in temperate climates, might, therefore, be short of this vitamin and if a purely dietary deficiency ever occurs, it is among vegetarians that the evidence might be found. Wokes et al. have investigated this matter. They appreciate the fact that the ordinary British vegetarian consumes quite a lot of animal protein in the form of milk, butter, cheese, and other dairy products. The proportion of total dietary calories he gets from animal protein is just under three per cent whereas in the average nonvegetarian diet in the United Kingdom, the figure is about six per cent. *Editorial. Nutrition and Vitamin B12. Lancet, Dec. 3, 1955.*

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## Prolonged hospitalizations

Many beds in state operated as well as private hospitals are occupied by patients who could be cared for in nursing homes or the homes of members of the family. Obituaries have been published recently in some of our newspapers recording the death of old people who were hospitalized from five to 13 years. *B. Frank Rosenberry, M.D. The Geriatric Viewpoint of Chronic Illness Problems and Solutions. Pennsylvania M. J. Nov. 1955.*

# COOK COUNTY HOSPITAL CASE RECORDS



## Volvulus of the Cecum

**Eli T. Samet, M.D.*, William McMillan, M.D.**, FACS and Edward Schnell, M.D.*, Chicago**

VOLVULUS may be defined as an obstruction caused by a twisting of the bowel upon itself so that its lumen is closed by the pressure of a part of the intestine continuous with it or its mesentery.[1] The degree of the twist (number of revolutions) determines whether a partial or a complete bowel and vascular obstruction occurs.

In the last five years (1949-1954 inclusive) only three cases of volvulus of the cecum could be found in the records of the Cook County Hospital.

River et al, in an excellent article, discuss the etiology of volvulus of the cecum. They state that "not only must hypofixation of an adequate degree be present but, that some degree of hyperfixation of the ileum, cecum or ascending colon supplies the fixed point of the rotation."[2] They conclude that this anatomic predisposition is the primary factor and that various physiologic maladjustments are the inciting cause.

The importance of recognizing this entity is that there is no survival with conservative treatment of the complete and non-reducing type. Reducing the volvulus and fixation of the cecum prevents recurrence.

The diagnosis depends on a history of bowel obstruction and certain X-ray criteria:[3]

1. Dilated cecum lying in a very abnormal position.
2. Loops of small bowel to right of distended cecum.
3. Ileocecal valve lying to right of distended viscus.
4. Twisted mucosal folds may occasionally be seen in simple films of abdomen by contrast with surrounding mucosa.

W.V., a 44 year old colored dishwasher, was admitted to Cook County Hospital on July 12, 1954 complaining of nausea, vomiting and generalized abdominal pain. He was "perfectly well" until two weeks prior to admission when he experienced mild episodes of nausea and generalized, cramping, abdominal pain which seemed to radiate into his right leg. These were relieved by self induced emesis and a laxative. He was asymptomatic until three days prior to admission when he awakened from his sleep nauseated followed by a vomiting episode. Four hours later he experienced intermittent cramping and lower abdominal pain every half hour for the rest of the night. On June 30, 1954, he was seen by a family physician who prescribed a sedative. On July 2, 1954 his family doctor recommended hospitalization.

The patient stated, on admission, that he had passed no gas per rectum or had a bowel movement for forty-eight hours but, that he had eaten only a small amount of liquids and no

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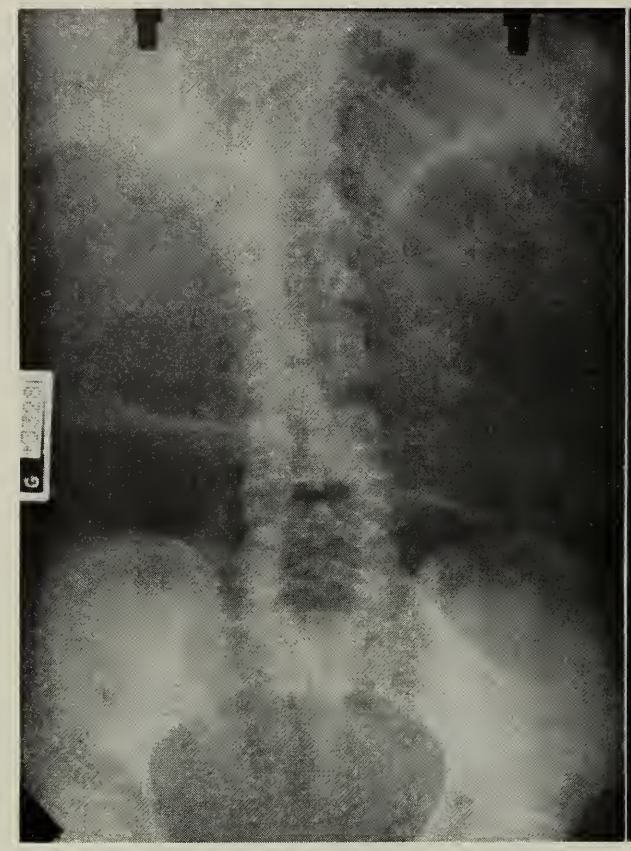


Figure 1. Flat plate of abdomen.

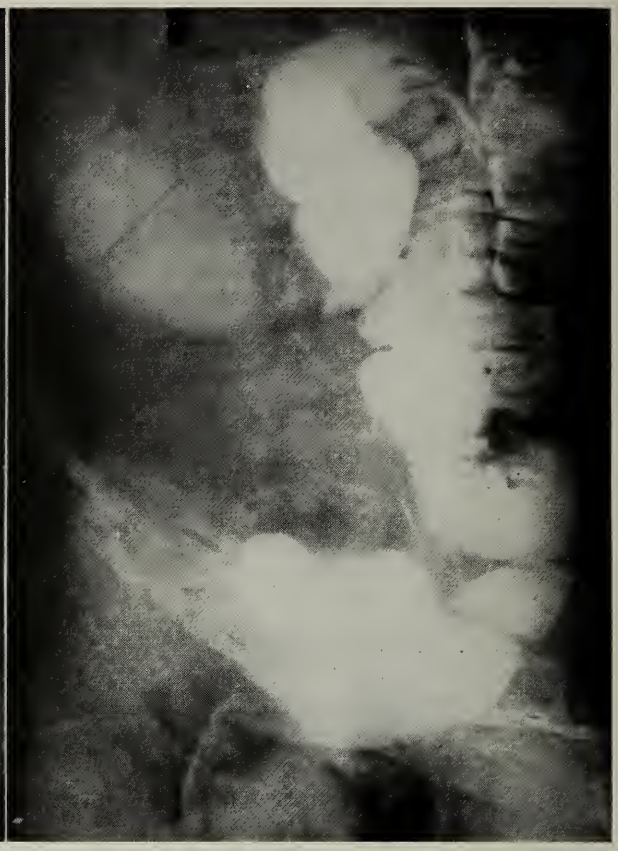


Figure 2. Barium enema.

solids in the past few days. He revealed that his emesis was at first clear, later green, but at no time black, red or feculent. For several years, he had experienced epigastric distress about one-half hour following meals which was relieved by food and soda. Other past and family history were non-contributory.

On admission, the physical findings were that of a well developed, well nourished colored male in some acute distress. The eyes, ears, nose, and throat were negative for pathology. The abdomen was distended, measuring thirty inches at the umbilicus. There were no operative scars, rigidity or localized tenderness but some generalized rebound was reported. The bowel sounds were hyperactive with occasional rushes but no high pitched tinkling sounds. The rectum contained no stool and the scrapings from the examining glove were benzedine negative. BP 130/104; Pulse 104; Temp 100°(R); WBC 8,400; hb 90%; Urine—negative for sugar, albumin, cells, acetone; NPN 40; Urine amylase 32; Blood Amylase 16; TP 7.7; Cl 95; Na 138; K 4.0; Alkaline Phosphatase 2.5.

W.V. was placed on Levine suction, and intravenous fluids. Emergency X-rays were ordered. The chest X-ray was normal. Flat plate of the abdomen (Figure 1) showed distended loops of small and large bowel but no air in the rectum. A barium enema (Figure 2) revealed an obstruction at the hepatic flexure with twisted mucosal folds at this point.

The patient was explored as an emergency. Loops of distended ileum were first encountered. The cecum and ascending colon were not in their proper position in the right iliac fossa. A mass, measuring approximately six inches in greatest diameter, which proved to be cecum, was located in the right upper quadrant. It was rotated approximately 180° in a counter-clockwise direction. After detorsion, it was found that the lateral peritoneal reflection of the ascending colon extended only about two inches from the hepatic flexure. The cecum, after reduction of the volvulus, was fixed in the right lower quadrant with interrupted fine black silk sutures.

The postoperative course was complicated by a period of electrolyte imbalance. A barium enema performed on July 20, 1954 was reported as normal. W.V. was discharged asymptomatic on August 4, 1954.

SUMMARY

A case of volvulus of the cecum in an adult male is presented. The diagnosis of this entity depends primarily on a history of bowel obstruction and certain X-ray criteria. Surgical intervention, with reduction of the volvulus and fixation of the cecum is the treatment of choice.

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## The pathologist

The story is told of the physician who went to a medical meeting one wintry day some years ago. Approaching the place of gathering, he noted a line of Cadillacs. "I see the surgeons are here," he said. Seeing next some Buicks, he stated, "The internists are here also." A line of Fords caused him to say, "Well, the pediatricians came too." He entered a building and noted a group of well worn, wet overshoes. "Ah!" he exclaimed, "and here are the pathologists."

Times really have changed, both professionally and economically, for the pathologist. No longer is he considered to be somewhat of a medical recluse who chose to fossilize himself with formaldehyde because he did not have the capabilities to become a surgeon or an internist. The modern clinical pathologist probably is expected to know more about the multitudinous fields of medicine both diagnostically and therapeutically than is any other specialist. Recent developments in medicine have drawn him intimately into contact with both the scientific practice and the administration of such fields as clinical chemistry, blood banking, radioactive isotopes, hematology, and forensic medicine, to mention only a few. The pathologist certainly is a leader in many of the facets of postgraduate medical education, as witnessed by the fact that in hospital after hospital, he is in charge of the teaching program for interns and residents and is responsible for the major part of the clinicopathologic conferences and the general staff meetings. *George G. Stilwell, M.D. Minnesota Med. Dec. 1955.*

## Not a waiting room

Parenthetically, let us never make the mistake of referring to the doctor's reception room as a waiting room. My father, who practiced general medicine in a New Jersey summer resort town for more than 60 years, was keenly aware of the distinction between a waiting room and a reception room. As far as I know, the well lighted, attractive, spacious, and comfortable room in which his patients awaited their turn to see him was never called anything but a reception room. *James E. Bryan. The Doctor and his Office. Pennsylvania M.J. Nov. 1955.*

# EDITORIALS




## The need for persistent efforts in the fight against cancer

Although much progress has been made in the treatment of cancer during the past two or three decades, our five and 10 year survival rates are far from ideal and we must continue the struggle for improvement. Although the five year survivals following treatment of certain cancers are as high as 80 to 90 per cent, in others it is below 15 or 20 per cent. In carcinoma of the head of the pancreas the expected five year survival rate following pancreatoduodenectomy is even less than five per cent. In this instance the lesion is so invasive that perhaps even extremely early therapy would yield poor results. However, in most cancers there is good evidence that very early recognition and therapy would yield markedly better figures for five years survival following therapy. Unfortunately, from the anatomical standpoint, we have just about reached the limit on the extent of resections. Accordingly, we must concentrate on earlier diagnosis and earlier therapy.

Fortunately, external cancers can be detected early in their development. Therefore with proper education and average care, we should be able to obtain those cases early in their growth. On the other hand, many or in fact most of the internal cancers start out insidiously. There is little doubt but what many may present no symptoms whatever for weeks or even months after their origin. Nevertheless, if we go into the history of most patients with internal cancer we will find significant symptoms for many months before the patient sought medical aid. It seems reasonable to assume that if we could obtain these patients for treatment a week or two after onset of symptoms, we might improve results of treatment very much indeed. Since symptoms are present in the vast majority of patients with cancer long before they came to the physician it should therefore be possible to obtain better results by efficient lay education.

Since symptoms of cancer often are similar indeed to symptoms of trivial diseases, it will be impossible to educate the lay individual to the point where he will know exactly when, and when not, to seek medical advice. Often it is very difficult for the physician to differentiate between symptoms of malignant disease and those of harmless malady.

Accordingly, if we are going to make significant improvement in our treatment of cancer, we will have to examine many patients with seemingly insignificant symptoms. When and if a specific blood test for cancer becomes available it will not be necessary to resort to physical examination.

In an effort to obtain earlier diagnosis and therapy, the American Cancer Society, Illinois Division intends to distribute leaflets this spring to lay individuals, emphasizing the great advantage of early diagnosis and treatment. One of these is entitled "Fight Cancer With a Checkup and a Check." It will be distributed in April at a time coinciding with the annual campaign for funds for the American Cancer Society. The Committee on Cancer Control of the Illinois State Medical Society has reviewed this leaflet and heartily approves its distribution. It will probably induce an increased number of patients to seek examination for cancer. Before

distribution to the lay public a copy of this leaflet will be sent to Illinois physicians for their information and to indicate when requests for examination might be expected. We hope that Illinois physicians will be very co-operative in acceding to requests from patients for examinations, because this is actually the only way we have at present of obtaining earlier diagnosis and treatment.

W.H.C.

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## Dr. Coggeshall named new aid to Folsom, welfare secretary

Dr. Lowell T. Coggeshall, member of the Illinois State Medical Society and University of Chicago biologist, is the new special assistant for medical and health affairs in the Department of Health, Education and Welfare.

Named by President Eisenhower, Dr. Coggeshall succeeds Dr. Chester S. Keefer, who resigned. Dr. Coggeshall is on leave of absence from the University of Chicago for a year to serve in his new federal position, which pays $15,000 annually.

Secretary Marion B. Folsom, in announcing the nomination which was subsequently confirmed by the Senate, said:

"Dr. Coggeshall is one of the nation's outstanding medical leaders. He has a distinguished record in medical research, teaching and administration. His skill and experience will be invaluable assets in the months ahead when important policy issues in the health field will be under consideration. I am delighted that he is joining the department."

The new assistant was born in Saratoga, Ind., 54 years ago and was educated at the University of Indiana. He was appointed dean of the University of Chicago's division of biological sciences in 1949.

The Chicago *Tribune* quoted Dr. Coggeshall as saying that in his appointment he will advocate the strengthening of the nation's medical research facilities, especially in the area of the basic sciences. He also will endeavor to find a solution to the mounting cost of medical care.

He emphasized that he is unalterably opposed to any kind of government control or domination over medicine and said that he is sure the programs he will seek to foster can be implemented without imperiling the spirit of free enterprise.

## Social Security — big '56 issue

Every physician who is conscious of his duties as a citizen should now be taking an active interest in a timely issue which the American Medical Association considers of great importance — not only to the medical profession but to all of the American people.

That issue is HR 7225, a bill passed by the United States House of Representatives last summer near the end of the Congressional session. This bill, known as the Social Security Amendments of 1955, was first rushed through the House Ways and Means Committee without public hearings. Then it was passed in the House, by a vote of 372 to 31, under a suspension of the rules which barred amendments and limited debate to 40 minutes. The Senate Finance Committee, however, refused to take hasty action on a bill of such major importance. After hearing the many serious questions raised by Mrs. Hobby, then Secretary of the Department of Health, Education and Welfare, the Committee decided to hold extensive public hearings during the second session of the 84th Congress.

Just what is this legislation that appears to be so politically attractive to individuals with an eye on the 1956 elections? Why was the House majority leadership so determined to avoid open hearings and normal debate? Let's take a brief look at the main provisions of the bill.

This is the legislation which would lower the Social Security retirement age for women from 65 to 62; extend monthly benefits for permanently and totally disabled children beyond the age of 18; expand compulsory social security coverage to all self-employed professional groups except physicians, and raise social security taxes over and above the increases already scheduled for the next twenty years. Those provisions alone demand careful study of their effects on the philosophy, scope, and financial stability of our social security system.

The most controversial section of the bill, however, is the one which would make permanently and totally disabled persons eligible to receive their social security retirement benefits at age 50 instead of 65. It is this section which is of particular concern to the medical profession. It is of far greater concern than the question of voluntary or compulsory coverage of physicians under the social security system. That

is a separate issue which we are not discussing in this editorial. The plan for a national system of permanent and total disability benefits has far more serious implications for medicine and the nation.

It raises questions such as these: Is there any real need for a federal program? What are the facts on permanent and total disability? Won't this duplicate or overlap existing programs of assistance and rehabilitation? What effect will cash handouts have on a patient's incentive to be rehabilitated? Won't this extend federal control over physicians? How will this program affect the future of medical practice? Will it lead, step by step, to the lowering and eventual elimination of the age-50 eligibility requirement; then, cash benefits for the dependents of those who are permanently and totally disabled; then, a temporary disability benefits program; then, cash benefits or direct government payments for hospital or medical costs, and then, ultimately, a full-fledged system of government health insurance?

These are but a few of the many grave questions which already have been raised concerning this legislation. As physicians, we must be concerned over the medical aspects of the problem. As citizens, we also must be concerned over the trends and implications in the never ending expansion of our social security system. The minority report of the House Ways and Means Committee expressed it this way:

"We do not believe that our committee has discharged its obligation to either the Congress or the American people by its brief and closed door consideration of this vital legislation. We have sought to point out the grave social and economic implications of the bill. We have dwelt at some length with the staggering ultimate costs of this developing program, because we do not believe that either the Congress or the public has any conception of its magnitude."

Our social security system now has reached the point where any further changes may have a profound influence on the nation's economic, social, and political future. The time has come to face up to the question of just what social security should accomplish and just where it should stop. The American Medical Association strongly *urges* that the social security issue be taken out of the arena of vote catching politics; that there be an objective, thorough study of social security in all its present and future aspects, and that the facts and realities emerging from such a study be used as the basis for a sound national decision on this vital issue. It especially protests precipitate action on the complex question of disability without thorough investigation of alternative mechanisms.

In our opinion, that is a reasonable, responsible policy that deserves the moral and intellectual support of every physician.

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## 4,000 physicians to attend Chicago clinical conference

Nearly 4,000 physicians will participate in the 12th Annual Clinical Conference of the Chicago Medical Society in the Palmer House, February 28-March 2. The four-day gathering will spotlight Chicago's leadership as a medical education center.

Prominent physicians from many parts of the country, most of them serving in a teaching capacity, will present a scientific program which will include all of the most important diseases of man.

More than 35 papers will be presented. Among the subjects which will be covered are current trends in allergy, the newer agents in the treatment of high blood pressure, evaluation of the infertile couple, accidental poisoning in children, heart lesions needing surgery, current problems in diabetes, common diseases of the skin, and the diagnostic features of breast lesions.

There also will be papers on arthritis, adrenal diseases, hernia, eye injuries, gastrointestinal diseases, tuberculosis, jaundice, painful shoulder and many other subjects.

One panel will cover "What's New in Medicine and Surgery." Another will deal with "Gall bladder." There will be daily teaching demonstrations in many subjects.

Question and answer periods will be devoted to hematology, diabetes, urology, isotopes and foot disorders. Luncheons will be marked by round table discussions.

The Woman's Auxiliary of the Chicago Medical Society will provide entertainment for visiting ladies.

Dr. H. Kenneth Scatliff is chairman of the executive committee handling the conference.

There is no registration fee for members of the Chicago Medical Society. For others, there is a fee of $5. Advance registrations and requests

for a program should be addressed to the Chicago Medical Society, 86 East Randolph Street, Chicago (1). Hotel reservations should be sent to the reservation department, Palmer House, State and Monroe Streets, Chicago.

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## Ralph P. Peairs, M.D. 1875-1955

Dr. Ralph P. Peairs, aged 80, died at his home in Normal, Illinois on December 18, 1955. He had apparently been in good health a few minutes before his death which was attributed to a heart attack. Dr. Peairs was born near Heyworth, Illinois, May 5, 1875. He attended Illinois State Normal University and was graduated from Rush Medical School in Chicago, 1903. He practiced in Milwaukee, Wisconsin until 1918 when he returned to Normal, Illinois.

He was appointed physician for the Illinois Soldiers' and Sailors' Children's School which position he held until 1933. His particular interest was in orthopedic surgery and during his period of service at the state institution, he was able to restore many crippled children to lives of usefulness. He conducted many crippled children's clinics over a period of many years, and for 17 years he was secretary of the McLean County Medical Society.

From 1937 until 1952, he was Councilor of the Illinois State Medical Society for the Fifth Councilor District. He was selected as the first president of the McLean County Board of Health, continuing in that capacity until his retirement. In 1913, he was married to Miss Myra Sinclair of Normal, who died in 1940. His second marriage was to Miss Nina Crigler, who survives. He has one son, Richard who lives in Columbus, Ohio, two daughters, Mrs. Fred A. Long, Whittier, California and Mrs. Louis E. Rames, of Palo Alto, California. He had four grandchildren.

Dr. Peairs will long be remembered by thousands of members of this State Medical Society who will join with the officers and Councilors of the Society in extending sympathy to the family of Dr. Peairs.

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## Roseola infantum

The following are the main characteristics of roseola infantum: It occurs nearly exclusively in the first three years of life. There is an initial febrile stage with fairly high pyrexia and little to account for it. It lasts several days, most commonly three. Rather surprisingly (hence the name, exanthema subitum) when the temperature is settling or has settled down, and the child is getting well, a rash like rubella or very mild measles appears and the illness ends. Complications scarcely ever arise. No fatal case has been described. Roseola infantum practically always confers permanent immunity to it. The great majority of cases reported have been sporadic but there have been some contact cases and descriptions of small epidemics, mainly in homes for babies, have been published. *A. Letchner, M.D. Roseola Infantum: A Review of 50 Cases. Lancet, Dec. 3, 1955.*

# MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

# Medical Ethics

Willard W. Fullerton, M.D., Sparta

A GREAT deal has been written and spoken about medical ethics in recent years. A code of ethics was handed down to us in the Oath of Hippocrates with which we were familiarized early in our medical training. The Hippocratic Oath is still the basis for our conduct, and medical ethics has not changed fundamentally throughout the centuries. This is due, probably, to the fact that ethics are much the same everywhere and at all times. Interpretations of the code are responsible for the controversial issues. The method of practice forces doctors to be more closely associated with each other in the care of patients and our code of ethics should be elaborated and defined more carefully and specifically.

In recent years, the chief discussions have been on the subject of fees, the question of fee splitting, and the various interpretations and the manner in which these are done. Much has been written, not only in medical circles but in lay publications about ghost surgery. Sometimes the comments have been most distasteful and not to the credit of the medical profession, particularly in the public press. In 1954 the Judicial Council of the American Medical Association handed down a statement of the recommended and accepted conduct of the medical profession in reference to the billing of the patient. This was well presented and outlined by Dr. Walter C. Bornemeier in the Medical Economics section of the October 1954 Illinois Medical Journal.

Quoting from Dr. Bornemeier's article:

"The Judicial Council is still of the opinion that when two or more physicians actually and in person render service to one patient they should render separate bills. There are cases, however, in which the patient may make a specific request to one of the physicians attending him that one bill be rendered for the entire services. Should this occur, *it is considered to be ethical if the physician from whom the bill is requested renders* AN ITEMIZED BILL SETTING FORTH THE SERVICES RENDERED BY EACH PHYSICIAN AND THE FEES CHARGED. THE AMOUNT OF THE FEES CHARGED SHOULD BE PAID DIRECTLY TO THE INDIVIDUAL PHYSICIAN WHO RENDERED THE SERVICE IN QUESTION."

"Under no circumstances shall it be considered ethical for the physicians to submit joint bills unless the services were actually rendered by unless the services were actaully rendered by the physician as set out in the bill." This final paragraph of the Judicial Council's report sums up the entire action. The statement in the preceding paragraph that "the fees charged should be paid directly to the individual physician" leaves no doubt of the intent of the Judicial Council and the House of Delegates in approving the report. A COMBINED, UNITEMIZED BILL COL-

LECTED BY ONE OF THE DOCTORS AND DIVIDED AS HE SEES FIT WITHOUT THE KNOWLEDGE OF THE PATIENT IS UNETHICAL. This practice along with "kickbacks, rebates, discounts, loans, favors, gifts and emoluments with or without the knowledge of the patient" should be promptly discontinued.

The past months have brought various resolutions for the consideration of the American Medical Association: the dispensing of drugs by physicians, doctor ownership of drug stores, and the dispensing of eye glasses by ophthalmologists. The controversies on these subjects were corrected during the June 1955 meeting of the House of Delegates of the American Medical Association.

The recommendation of this reference committee was based on Section 8, Chapter I of the Principles of Medical Ethics which reads:

'OWNERSHIP OF DRUGSTORES AND DISPENSING OF DRUGS AND APPLIANCES BY PHYSICIANS

'Sec 8.—It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society. The same principle applies to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy and coercion are employed or if financial interest is placed above the quality of medical care. On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients can not procure from other sources.'

The Committee recommended the following in lieu thereof:

'DISPENSING OF DRUGS AND APPLIANCES BY PHYSICIANS

'Sec. 8—It is not unethical for a physician to prescribe or supply drugs, remedies, or appliances as long as there is no exploitation of the patient.'

These statements affirm that the use or supply of these articles is not to be a source of increased income to the doctor or at least not a means by which the doctor can extort more money from the patient. The subject of doctor ownership of drugstores of course stands as a controversial issue.

The foregoing paragraphs of this article have been confined primarily to controversial issues which have had some decisions handed down. Some of these are pretty well settled and at least have been stated definitely enough to be a guide to our ethical conduct in respect to professional demeanor towards the patient and the public. However, the purpose of this article is not primarily concerned with this phase of medical ethics.

The function of medical organizations is to bind ourselves together so that we not only improve ourselves educationally and scientifically, but also that we may render better service to our patients. The ultimate purpose of medical organization, therefore, is to render better service and better medical care and thereby to be of greater value to the public. Another phase in medical organization is to exchange ideas among ourselves, to improve relationships among ourselves and to bind ourselves together to protect our own interests. Furthermore, a function of medical organizations is to promote better fellowship among physicians. The purpose of this article is to bring out a few points of our responsibility to each other as far as medical ethics are concerned. It does not improve our prestige as a group of physicians, or as an individual physician, when we allow ourselves to discredit another physician in public or in private conference with a patient. It behooves us at all times to be careful of our attitudes when we are observing another doctor's patient or another doctor's prior patient. It is easy for us, when we are busy, to see a patient, whom some other doctor has observed and treated, see results not being secured which probably should be secured, and hurriedly take over. Thus, even without words, we discredit the prior treatment. A disapproving expression can easily start a law suit. Doctor shopping is the mode in these days of specialization because patients do not know where to go. They shop from one doctor to another, sometimes from one specialist to another, and doctors are beginning to get the idea that while the patient is in his office he is my patient, and when he leaves my office he is just a patient. It is high time we cultivated a personal fellowship with our patients.

(*Continued on page* 105)

# THE P. R. PAGE



**Sage advice on PR**

Sage advice on public relations was given by Dr. Walter L. Portteus, retiring president of the Indiana State Medical Association at the last annual meeting of that group. In presenting a positive program, he said:

"Medicine has long been on the defensive and is often accused of being opposed to so-called progressive ideas. Part of this stems from the lack of imagination and planning and part from the complacency of all of us as individuals. Therefore, join all lay health organizations in a co-operative spirit and help guide their working principles to the betterment of all.

"Be citizens first and doctors second and you will be interested in more than the scientific practice of medicine. Be patient with and helpful to your legislators as they, too, are being subjected to terrific pressures beyond their control. To know your congressman better, I would urge that the annual trip to Washington be maintained so that your own congressmen will be aware of our thinking.

"As individuals remember your obligation to voluntary insurance programs; do not abuse or overuse its potentials. Learn to work with and understand its basic philosophy.

"Meet with representatives of all professions, labor, legal, farm, and veterans' organizations. You will be astounded when you see both sides of the questions involved. As an example, medicine and law should smooth out areas of misunderstanding concerning medical expert witnesses, workmen's compensation cases, and other relationships which should obviate delays for all concerned.

"Be willing to discuss fees on a prior basis and give advice as to insurance coverage when necessary. As you know, so-called overcharging is a fertile field for malpractice suits. A patient can comprehend medical costs and is likely to be disgruntled unless he has received an explanation beforehand. We as doctors are the only ones who are trained to judge the necessity and skills employed in treatment.

"Hence, we as physicians must exert our influence over the small percentage of our colleagues who give us a bad reputation, to the end that they will be conscious of their obligations as men of medicine. This to be done efficiently and quietly so that we do not hang our dirty linen on the line for public view."

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**AMA's PR program for 1956**

The AMA Public Relations Department has announced its PR program for 1956. It will cover:

(1) Production of a new 28-minute television film for the public, highlighting some phase of medicine's positive story of public service.

(2) Production of a 16 mm. motion picture film to answer physicians' questions about the AMA and to acquaint members with the services offered.

(3) Encouragement of medical societies in the sponsorship of or participation co-operatively

with civic groups in high school science fairs.

(4) Release of the results of a nationwide survey conducted in 1954 and 1955 on "What Americans Think of the Medical Profession." Medical societies will be asked to help bring this information to the attention of the profession and public.

(5) Publication of three additional pamphlets for distribution at county and state fairs.

(6) Co-sponsorship with Association of American Medical Colleges, American Medical Education Foundation, the National Fund for Medical Education, and the Woman's Auxiliary to the AMA in a nationwide Medical Education Week, April 22-28; state and county societies will be asked to promote the program locally.

(7) Closer liaison with the press with the assistance of state and county medical society executives.

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**New AMA PR aids**

The American Medical Association has announced several new aids for PR programs of county medical societies.

Its Bureau of Health Education will put out three new radio transcription series of 13 programs each for use by county societies over local stations. These will be livened by music.

The first will feature a "music with your meals" theme. Dr. W. W. Bauer, bureau director, will give a medical commentary based on 13 phases of diet and nutrition. An instrumental trio will render folk songs, ballads, and semi-classics.

The second series, entitled "Summer Serenade," will deal with summer situations, such as having fun while avoiding illness and accidents. The format and subject of the third are to be chosen. Probable releases will be April 1, August 1, and November 1.

Two booklets of vital interest to medical societies have just been published and may be obtained from the AMA Council on Medical Service. One is "Guides for Medical Society Grievance Committees," which reviews findings and recommendations of a special committee appointed by the AMA Board of Trustees. The other is "Report of the Survey on County Medical Society Activities," which covers data on society meetings, budgets, educational and scientific programs, personnel, building facilities, work of committees, and public relations activities.

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**Promote emergency service**

As a result of the activities of the Public Relations Committee of the Adams County Medical Society, the telephone directory of Quincy now carries an advertisement relative to telephoning a physician in an emergency.

The advertisement appears under the heading "Physicians and Surgeons Information Exchanges" and immediately before the telephone listing of "Physicians and Surgeons (M.D.)" of Quincy. It reads:

> IN AN EMERGENCY
>
> DIAL BA-5088
>
> Adams County Medical Society
> Physicians' Exchange
> If Unable to Locate Your
> Physician (M.D.)
>
> A private physician will be contacted
> if your physician cannot be located

The cost is borne by the Adams County Medical Society from the budget allotted to its Public Relations Committee.

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# CORRESPONDENCE



## A.M.A. conference on rural health

The 11th National Conference on Rural Health will be held at the Multnomah Hotel, Portland, Oregon, March 8-10, 1956. In accordance with the practice in former years, an informal pre-conference session for members of the medical profession will be held March 8, beginning at 9:00 a.m.

A cordial invitation is extended to members of the medical profession to attend and participate in this important session, which will be devoted to a frank and full discussion of some of their problems.

Physicians desiring to attend this conference should write to the Multnomah Hotel to assure proper accommodations. The completed program may be procured by writing to Mrs. Arline Hibbard, Secretary, Council on Rural Health, 535 North Dearborn Street, Chicago 10, Illinois.

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## Public health scholarships

Harvard University School of Public Health announces that scholarships for the academic year 1956-57 will be granted to individuals of high professional promise in awards ranging from part tuition to tuition plus a stipend, according to the qualifications and financial needs of the applicants. The scholarship funds are limited and are primarily intended for citizens of the United States. In general, preference will be given to applicants under 35 years of age.

Scholarships are available to those in the following categories who wish to obtain post-graduate education in the field of public health or in one of the basic sciences related to public health: physicians, dentists, and veterinarians; industrial physicians; public health nurses with a college degree and satisfactory field experience; social workers with a master's degree from an approved school of social work and acceptable experience in the field of medical or psychiatric social work; health educators with a college degree, training either in health education or in the natural and social sciences and experience in general education or community health work; dietitians with a college degree and satisfactory field experience; college graduates who have concentrated in one of the natural sciences or in engineering (environmental aspects), including biologists, biochemists, nutritionists, microbiologists, parasitologists, or biostatisticians.

Scholarship applicants must be eligible for admission to the School as candidates for one of the following degrees: Master of Public Health, Doctor of Public Health, Master of Science in Hygiene, Doctor of Science in Hygiene, or Master of Industrial Health.

A catalogue of the School, Admission and Scholarship applications and further information may be obtained by writing the Secretary, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Massachusetts.

Scholarship applicants must return completed admission and scholarship applications to the Harvard School of Public Health by March 1, 1956. Scholarship awards will be announced May 1, 1956. Under exceptional circumstances awards will be made at other times.

## Clinics for crippled children listed for March

Twenty five clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The March clinics are:

March 6—Alton, Alton Memorial Hospital
March 7—Centralia, Recreation Center
March 7—Hinsdale, Hinsdale Sanitarium
March 7—Rock Island Cerebral Palsy, Foss Home, 3808 - 8th Avenue
March 8—Elmhurst Cardiac, Memorial Hospital of DuPage County
March 8—Springfield, St. John's Hospital
March 8—Sterling, Field House
March 9—Chicago Heights Cardiac, St. James Hospital
March 13—E. St. Louis, St. Mary's Hospital
March 13—Peoria, Children's Hospital
March 14—Joliet, Will County T.B. Sanitarium
March 14—Jacksonville, Passavant Hospital
March 15—Sparta, Sparta Community Consolidated School
March 16—Evanston, St. Francis Hospital
March 20—Shelbyville, Methodist Church
March 21—Evergreen Park, Little Company of Mary Hospital
March 21—Springfield (Cerebral Palsy), Memorial Hospital
March 21—Metropolis, Presbyterian Parish House
March 22—Bloomington, St. Joseph's Hospital
March 22—Rockford, St. Anthony's Hospital
March 23—Chicago Heights Cardiac, St. James Hospital
March 27—Effingham (Rheumatic Fever), St. Anthony's Hospital
March 27—E. St. Louis, Christian Welfare
March 27—Peoria, Children's Hospital
March 28—Aurora, Copley Memorial Hospital

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## "Clinical reviews"

A 3 day program entitled "Clinical Reviews" will be presented April 9, 10, and 11, 1956, at Rochester, Minnesota. The presentations will be given by staff members of the Mayo Clinic and the Mayo Foundation for Medical Education and Research. The meeting will be devoted to lectures and discussions on problems of current interest in general medicine and surgery.

The number of physicians who can be accommodated is necessarily limited. Those wishing to attend should communicate with Mr. R. C. Roesler, Mayo Clinic, Rochester, Minnesota. There are no fees of any kind.

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## Graduate instruction course in allergy

The American College of Allergists will conduct a Graduate Instructional Course at the 12th Annual Meeting of that organization.

*Place*: Hotel New Yorker, New York City.

*Time*: April 15, 16, 17, 1956 — Graduate Instructional Course April 18, 19, 20, 1956.

For additional information, write to:

Fred W. Wittich, M.D.
Secretary-Treasurer
401 Marquette Bank Bldg.
Minneapolis 2, Minn.

FWW: iw

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**MEDICAL ETHICS (Continued)**

one of us pledge, regardless of our station in the medical picture (specialist, general practitioner, educator, professor) to accept the responsibility of treating every physician with the respect that is due all physicians unless he proves to the medical society that he does not deserve it. This is the Old Code of Ethics for the Medical Profession and even today it is—*fundamental.*

# AT THE EDITOR'S DESK



Editors of medical journals receive the same news releases on medical topics that are sent to the editors of newspapers, magazines, radio, and TV. Some of this material is relegated to the wastebasket; some is worthy of comment. From time to time your editors will mention a few of these items in the Journal. This does not constitute an endorsement of the products or procedures, and it is well to remember that the originals were prepared for lay consumption.

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Abbott Laboratories and the Upressit Products Corp. have developed a new spring steel safety bottle cap to prevent children from opening an aspirin bottle. The cap is no problem for the adult but requires more strength, co-ordination, and comprehension that a child is capable of. It is hoped that this device will increase the safety of the medicine chest. Ignorant misuse of drugs is responsible for two per cent of accidental deaths in children under 5; and poisoning from accidental ingestion of medications represents up to one per cent of the total.

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The Beltone Hearing Aid Co. has presented $7,000 to Northwestern University Medical School for a new soundproof hearing laboratory, to be used in making hearing tests. One of the first major projects will be a study to determine whether a hearing aid for both ears will be of more help to the hard of hearing than the usual one ear device. The idea is to overcome the intolerable confusion of crowd noises that bothers many wearers of hearing aids.

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A Professor of Social Welfare from the Florida State University, reported on a new study of people's feelings toward physicians and hospitals. The main criticism was that physicians and hospital personnel lacked the human warmth of the oldtime general practitioner; they give the impression of "not caring deeply about the human patient." Of the group interviewed, 19 per cent thought physicians charged too much; 82 per cent believed hospital costs are high; and 71 per cent said hospital care is unsatisfactory. One-half criticized the unwillingness of physicians to make house calls. The old family doctor never will be forgotten. The Professor conducting the questionnaire failed to ask the persons interviewed whether they would like to set back the clock and receive the horse and buggy remedies dispensed by oldtimers.

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A new germicide, chlorpactin WCS-90, a derivative of chlorine, caused dramatic improvement in 48 victims of chronic interstitial cystitis. According to the news release the majority of these patients had not responded to other medications but "spectacular improvement was achieved" with chlorpactin.

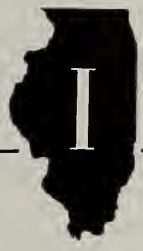
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Cetadiol, a new steroid compound, was used in the treatment of 43 advanced alcoholics. The news release says the product put them on the road to full recovery in an amazingly short time. Apparently the drug affects the brain; it exerts a sedative effect upon the nervous system so that it is unnecessary to use barbituates or sedatives.

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The tobacco cancer scare was followed by a drop in the total consumption of cigarets in 1954. But the industry staged a partial recovery in 1955 when smokers switched from regular to the filter type. King size smokes held their own.

# NEWS of the STATE




## ADAMS

**Medical Secretaries and Assistants.**—The Swanberg Medical Foundation was the original sponsor of what is now known as the Adams County Medical Secretaries and Assistants Club. When the club was organized in 1951 this Foundation contributed $1.00 for each of the club's charter members. Later it gave each club member a copy of "Letters to a Doctor's Secretary" ($2.00 per copy), published by Medical Economics. In November the Adams County Medical Society paid out of its Public Relations Budget the expense to send two members of the Adams County Medical Secretaries and Assistants Club to the national convention of medical secretaries held in Kansas City, Missouri. The Society and its Foundation are greatly interested in the medical secretaries' organization and wish to commend it on its regular meetings. The latest activity of the Adams County Club is to sponsor the formation of an Illinois State Club to be affiliated with the new national organization which is being organized.

## COOK

**Alcohol and Emotional Problems to be Studied With New Grant.**—The department of neurology and psychiatry of Northwestern University Medical School has received a grant of $26,000 from the Illinois state department of welfare to study the effect of alcohol on the ability of a person to cope with emotional problems. This study will be the initial step in a broad research program on narcotic addiction and will be carried on under the direction of Drs. G. K. Yacorzynski, professor of neurology and psychiatry and Harvey Nash, Associate.

How persons handle complex psychological problems will be tested, first, in those given moderate amounts of alcohol and, second, in those given only grape juice and peppermint oil, which tastes the same. Over 900 total hours of testing are planned.

Tests will be given on the capacities of subjects to comprehend their environment in all its complexity, to bring relevant aspects of their past experience to bear in dealing with current problems, to pursue their goals in face of external or internal distraction, to decide wisely between alternate courses of action and to cope with strong emotions by putting them to constructive use.

**Fund for Patients Needing Transfusions.**—A fund has been established by Mr. and Mrs. Sam Sherman of Chicago to aid patients having diseases of the blood and blood forming organs, who require blood transfusions or certain special therapeutic agents. The fund, administered by the Hematology Research Foundation, is in memory of Stanley Sherman, a victim of leukemia. Applications for funds for blood transfusions may be discussed with Dr. Raphael Isaacs, 104 South Michigan Avenue, Chicago, Illinois.

**First James B. Herrick Memorial Lecture.**—Dr. George E. Burch, chairman of the department of medicine of Tulane University School of Medicine, New Orleans, presented the first James B. Herrick Memorial Lecture under the auspices of the Chicago Heart Association, January 24, 1956. Title of the lecture was "Clinical Management of Congestive Heart Failure Including Certain Aspects of Its Relationship to Venous Tone."

**Personal.**—Dr. Joseph H. Chivers, medical director of the Crane Company since 1936, has been elected medical director of the Rehabilitation Institute of Chicago, a non-profit institution concerned with the physical restoration of disabled persons. Dr. Chivers, who will serve as the chief medical officer of the institute, has resigned as volunteer head of the Medical Advisory Committee of the institute to take on his new activities.—John G. Searle, Chicago Medical Research and Pharmaceutical Manufacturing executive, was given a fellowship in the Institute of Medicine of Chicago, December 6, 1955, in recognition of his long time work in behalf of education of the public in fields related to medicine. The fellowship was conferred by Dr. Arthur R. Caldwell at the Institute's fortieth an-

nual dinner.—Dr. Maurice W. Sbertoli, Evanston, has been elected president of the medical staff at St. Francis hospital, Evanston. He succeeds Dr. George H. Irwin, also of Evanston.—Dr. Walter H. Theobald has been re-elected to his tenth consecutive term as president of the Medical Center Commission.—Dr. Herbert E. Schmitz was re-elected treasurer of the American Academy of Obstetrics and Gynecology at a recent meeting in the Conrad Hilton Hotel.

**Hospital News.**—Evanston hospital has received a $25,000 contribution for a new maternity clinic from the family of Henry Crown, chairman of Meterial Service Corporation, which includes Dr. Edward A. Crown, an obstetrician and a member of the staff.—Shriners Hospital for Crippled Children recently received a $50,000 check which represented the proceeds of the annual Shrine circus held last spring.

**Blatt Memorial Lecture.**—The seventh annual Maurice Lamm Blatt Memorial Fund Lecture was given October 24, under the auspices of the Pediatric staff of the Cook County Hospital. Wolf W. Zuelzer, director of laboratories of the Children's Hospital of Michigan, gave the lecture on "Maternal Fetal Incompatibility in the O-A-B-System and Hemolytic Disease of the Newborn."

**Northwestern Instructor Wins Trip to Hawaii.**—Dr. Sherman S. Coleman, Northbrook, winner of an all-expense to Hawaii for submitting the best paper on bone irregularities in a contest sponsored by the Western Orthopaedic Association, delivered the award-winning paper in Honolulu, November 8, at an assembly of the association. Dr. Coleman, an instructor in orthopedic surgery at Northwestern University Medical School, had as his subject the diagnosis of congenital dysplasia of the hip in the newborn infant in which the hip bone develops abnormally before birth.

**Society News.**—Dr. Leon Feldman, associate professor of medicine, University of Illinois College of Medicine, discussed "Diagnosis of Rheumatic Heart Disease" at a special meeting in Provident Hospital in cooperation with the Chicago Heart Association. The lecture was held in the auditorium at Provident Hospital, January 11.

**New Society.**—The Central Society of Nuclear Medicine was recently organized as a regional group to encourage and promote interest, work and investigation in the field of Nuclear Medicine. Membership is open to physicians and other professional workers in the field. Present plans are to have three meetings each year. Officers of the society are: Irvin F. Hummon, M.D., president; Donalee Tabern, Ph.D., vice-president; Ervin Kaplan, M.D., treasurer and Robert S. Landauer, Ph.D., secretary.

## DUPAGE

**Society News.**—Dr. Oglesby Paul, associate clinical professor of medicine, University of Illinois College of Medicine, discussed "Rheumatic Carditis" at a meeting of the Dupage County Medical Society, January 18. The lecture was under the sponsorship of the Chicago Heart Association.

## KANKAKEE

**New Officers.**—Dr. Herbert P. Schwartz, Kankakee, was installed as president of the Kankakee County Medical Society at a recent meeting. Dr. Henry A. Hartman, Kankakee, was chosen president-elect, and Dr. Sheldon W. Reagan, Aroma Park, was re-elected secretary. Dr. Charles Allison, Kankakee, was named delegate to the Illinois State Medical Society, and Dr. Donald A. Meier, St. Anne, was named alternate delegate.

## KNOX

**Society Election.**—Dr. G. K. Smart, Galesburg, was elected president of the Knox County Medical Society, November 17, 1955. Dr. Milo Reed, Galesburg, was chosen vice-president and Dr. Fred Stansbury, was re-elected secretary-treasurer. Dr. Merrill Beecher was named delegate to the Illinois State Medical Society. The speaker for the evening, Dr. William R. Best, assistant professor of medicine, University of Illinois College of Medicine, gave an excellent presentation on "Blood Disorders."

**Society Guest of State Hospital.**—The Knox County Medical Society were guests of the Galesburg Research Hospital at a meeting in December. Dr. Harold Himwick spoke on "Uses of Thorazine and Reserpine in Mental Cases" and Dr. Henry Venclauskas conducted a clinical pathological conference. Dr. Lester Rudy, the hospital superintendent, acted as host and moderator during the evening session. The Committee on Poliomyelitis of the Knox County Medical Society gave some excess vaccine to the Lillian Taylor School where innoculations were carried out recently. The vaccine had been left over from the school program in the fall.

## LAKE

**New Officers.**—At the December 13 meeting of the Lake County Medical Society, the following officers were elected; Drs. John Milroy, president, Lawrence Qualman, vice-president; M. J. McAndrew, secretary; Gerald Dean, treasurer; Kenneth Morris, Board of Censors three year term; Asa Myers, Victory Memorial Hospital Board; Douglas Boyd, Grievance Committee one year term; William Ewals and Robert Robbins, Grievance Committee three year term; George Callahan, delegate and William Darnall, alternate. At this meeting, the transfer of Dr. Hugh Bernardi from the Lake County Medical Society, Indiana, to the Lake County Medical Society, Illinois, was approved.

## ST. CLAIR

**Society News.**—Dr. John Deyton, medical director of Miriam Rehabilitation Division, Jewish Hospital, St. Louis, discussed "The Role of the Physiatrist as a Consultant in the Management of Rehabilitation

Problems" before the St. Clair County Medical Society at the Trailway Restaurant, January 5.

## SANGAMON

**Society Election.**—Dr. Emmet F. Pearson was chosen president of the Sangamon County Medical Society for the coming year. Dr. A. E. Steer was named vice-president and William DeHollander, secretary. Delegates to the Illinois State Medical Society are Drs. Kenneth Schnepp and Darrell H. Trumpe. Their alternates are Drs. Thomas F. Harmon and J. Marvin Salzman. Physicians making up the board of directors for the society are Dr. Pearson, chairman; Dr. DeHollander, secretary; Franz K. Fleischli, Thomas F. Harmon, Paul LaFata, David J. Lewis, J. Keller Mack and Jacob E. Reisch.

**Medical-Community Teamwork.**—A panel discussion on Medical-Community Teamwork was the feature of the Sangamon County Medical Society at the Elks Club, January 5. Making up the panel were Nelson Howarth, Mayor; Carl Carter, president of the Association of Commerce and Industry; George Blanchard, president of the United Community Services, and Walter Oblinger, associate counsel of the Illinois State Medical Society. A highlight of this meeting was the Annual Memorial Service to deceased members of the society, conducted by Rabbi Lewis Satlow.

## VERMILION

**Society News.**—Dr. Harold C. Lueth, Evanston, member of the Federal Board of Civilian Defense, addressed the Vermilion County Medical Society at the Hotel Wolford, Danville, January 3, on "Danville's Role in Civilian Defense."

**Special Society Election.**—Dr. M. S. Parker was elected president of the Vermilion County Medical Society at the December 6 meeting. Other officers chosen are Drs. E. F. Dietrich, vice-president, and L. W. Tanner, secretary-treasurer. Dr. J. E. Urbas was named alternate delegate and Dr. J. W. Moore, delegate to the Illinois State Medical Society. Dr. Harlan English, Danville, is councillor for the Eighth District.

## WABASH

**Three Physicians Honored.**—Fifty year emblems were presented to Drs. J. J. McIntosh, Mt. Carmel; C. F. Brian, Bellmont, and C. E. Gilliatt, Allendale, December 8, 1955. The fifty year awards are emblematic of membership in the Fifty Year Club of the Illinois State Medical Society. The physicians, who have completed fifty years or more in the practice of medicine, are still active. Dr. Burtis Montgomery, councilor for the Ninth District, made the presentation and Dr. Edmund F. Foley, Chicago, spoke. Among the physicians honoring the three doctors of medicine was Dr. Andy Hall, Mount Vernon, who, a few years ago, was chosen the outstanding general practitioner of the year by the American Medical Association.

## GENERAL

**CIO Health Center.**—The Sidney Hillman Health Center, the nation's fourth health center to provide medical care for CIO unionists in the clothing industry was recently dedicated by the CIO Amalgamated Clothing Workers of America. It occupies two floors of the Amalgamated center at 333 S. Ashland Ave. Its staff, headed by Dr. William S. Hoffman, professorial lecturer in medicine at the University of Illinois College of Medicine, will include thirty specialists and a staff of technicians.

**Expectation of Life at Birth.**—In Illinois the expectation of life at birth at the midcentury was 66.0 years for white males and 71.6 years for white females, according to a recent release from the Metropolitan Life Insurance Company. For the United States population as a whole, as reported by the National Office of Vital Statistics, a part of the Public Health Service, the comparable figures are 66.3 years for males and 72 years for females. The release stated that the midcentury figures for Illinois mark a gain of 3.1 years for males and 4.1 years for females over those for 1940.

**"Your Doctor Speaks" on FM Station WFJL.**—The following physicians have recently appeared in transcribed broadcasts of FM Station WFJL, Thursday evenings at 7:45 p.m. The series, entitled "Your Doctor Speaks," is presented by the **Educational Committee** of the **Illinois State Medical Society:**

**Joseph E. Alfano,** instructor in ophthalmology, Northwestern University Medical School, December 22, on Cataract.

**Frederick W. Preston,** assistant professor of surgery, Northwestern University Medical School, December 29, on Progress in the Treatment of Cancer.

**Harry B. Harding,** professor of bacteriology, Northwestern University Medical School, January 5, on Microbes and Viruses.

**R. Charles Oldfield, Jr.,** clinical assistant in surgery, Northwestern University Medical School, January 12, on Cancer of the Lung.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Donald H. Atlas,** associate professor of medicine, Chicago Medical School, St. Phillip Partners' Club, February 5, on Know Your Heart.

**John B. Hall,** director, Cook County department of public health, Solomon School PTA, March 13, on Polio and the Salk Vaccine.

**Harold H. Dubner,** psychiatrist in charge at Parkway Sanitarium, Woman's Auxiliary to the Southern Cook County Branch of the Chicago Medical Society, March 27, on Mental Health.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Armand J. Mauzey,** clinical assistant professor of obstetrics and gynecology, University of Illinois College of Medicine, LaSalle County Medical Society at the Kaskaskia Hotel, LaSalle, January 12, on Office Gynecology.



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**William R. Requarth**, assistant professor in surgery at the University of Illinois College of Medicine, Knox County Medical Society at the Galesburg Club, Galesburg, January 19, on Hand Injuries.

**Peter J. Talso**, associate professor and assistant chairman of the department of medicine, Stritch School of Medicine of Loyola University, Calumet Branch of the Chicago Medical Society, January 27, on Cardiovascular Aspects of Aging.

**J. Henry Heinen, Jr.**, graduate of the University of Chicago School of Medicine, Knox County Medical Society at the Galesburg Club, Galesburg, February 16, on Common Orthopedic Problems.

**William R. Best**, assistant professor of medicine, University of Illinois College of Medicine, Lee and Whiteside County Medical Societies at the Plum Hollow Country Club, Dixon, March 15, on New Developments in Diagnosis and Treatment of Blood Dyscrasias.

**Benjamin Boshes**, professor and chairman of the department of neurology and psychiatry, at Northwestern University Medical School, DeKalb County Medical Society at the Bishop McLaren Foundation, Sycamore, March 27, on Psychosomatic Aspects of Medicine.

## DEATHS

**Marion K. Bowles***, retired, Joliet, who graduated at Northwestern University Woman's Medical School in 1894, died December 30, aged 90. She was a former president of the Will-Grundy County Medical Society.

**John Edmond Bryant***, Evanston, who graduated at Howard University College of Medicine, Washington, D. C., in 1937, died December 13, aged 54.

**Carroll Eugene Cook***, retired, Oak Park, who graduated at Rush Medical College in 1897, died December 19, aged 80. He was chief consultant and head of the radiological department of the Municipal Tuberculosis Sanitarium from 1923 to 1945.

**William Warren Fox***, Lincoln, who graduated at the University of Illinois College of Medicine in 1932, died November 16, aged 48, of hemorrhage from duodenal ulcer. He was a past president of the Logan County Medical Society and medical superintendent of the Lincoln State School and Colony.

**Jack L. Greider***, Decatur, who graduated at Marquette University School of Medicine, Milwaukee, in 1945, died in December, aged 35.

**Robert H. Hayes***, Lake Villa, formerly of Chicago, who graduated at the University of Pennsylvania School of Medicine in 1906, died December 10, aged 76. He was a member of the staffs of the Illinois Masonic and American Hospitals, and a former president of the Chicago Medical Society.

**Harry Winfield Kinne***, West Chicago, who graduated at the Chicago College of Medicine and Surgery in 1908, died in the Sherman Hospital, Elgin, November 3, aged 68, of coronary thrombosis and diabetes mellitus. He was a member of the staffs of the Community Hospitals in Geneva and Delnor Hospital in St. Charles.

**Gottfried Koehler***, retired, Bonita Springs, Florida, formerly of Chicago, who graduated at Northwestern University Medical School in 1902, died December 18, aged 77. He served as assistant health commissioner of Chicago for many years; from 1932 to 1946, he was a school physician in Springfield.

**Warren Gordon McPherson***, Bement, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1901, died November 15, aged 80, of myocarditis and arteriosclerosis. He was a member of the staffs of the Decatur and Macon County Hospital in Decatur, and the Kirby Hospital in Monticello.

**Jacob Meyer***, Chicago, who graduated at Rush Medical College in 1916, died January 12, aged 61. He was senior attending physician at Michael Reese Hospital and a former president of the staff.

**Benjamin S. Milton***, Chicago, who graduated at Wisconsin College of Physicians and Surgeons in 1898, died December 22, aged 85. He was a member of the staff of St. Elizabeth's Hospital for 25 years.

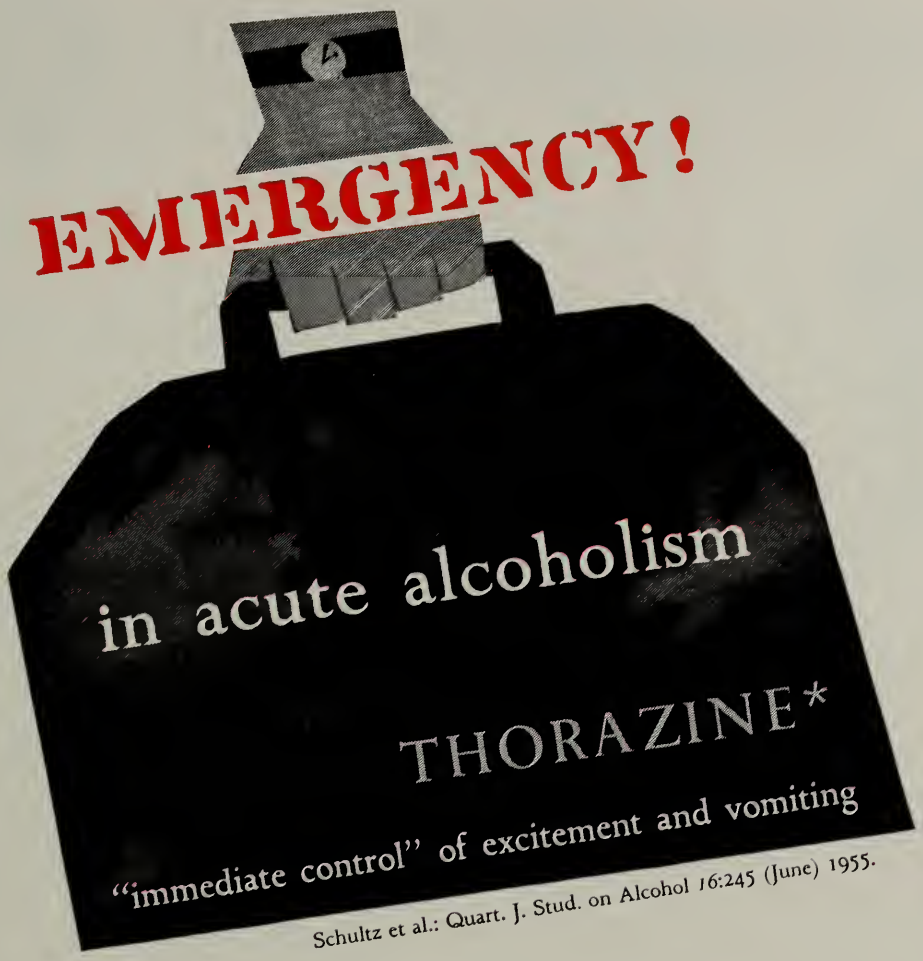
**David Monash***, Chicago, retired, who graduated at Columbia University College of Physicians and Surgeons, New York City, in 1893, died November 5, aged 84. He was a member of the staff of Mercy Hospital.

**Vincent V. Mullen***, Havana, who graduated at the Chicago Medical School in 1935, died recently, aged 55.

**Ralph P. Peairs***, retired, Normal, who graduated at Rush Medical College in 1903, died December 19, aged 80. He was a member of the Council of the Illinois State Medical Society for many years.

**Jacob Stern***, Chicago, who graduated at the University of Illinois College of Medicine in 1916, died December 20, aged 61. He was a member of the staff of the South Chicago Community Hospital for 35 years.

*Indicates member of the Illinois State Medical Society




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# BOOK REVIEWS

TEXTBOOK OF PEDIATRICS by Waldo E. Nelson, M.D. Sixth Edition. 1581 Pp. 478 Illustrations. W. B. Saunders Company, Philadelphia $15.00.

This voluminous work is an excellent presentation of the present thinking in the field of pediatrics. Its contributors are a veritable "who's who" in this particular field. The whole subject is excellently covered. References are excellent and printing and reproductions leave nothing to be desired, in the opinion of this reviewer.

It seems a pity that this excellent work could not be kept immediately up to date by publishing it as a loose leaf volume. J.O.E.

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PRACTICAL FLUID THERAPY IN PEDIATRICS by Fontaine S. Hill, M.D. 275 Pp. Illustrated. W. B. Saunders Company, Philadelphia — London. 1955. $6.00.

This book is exactly what the title implies; a practical and understandable discussion of the value of proper fluids and electrolytes in diseases of children. This book, in the opinion of this reviewer, fills a long-felt need of the general practitioner who, after all, sees the great majority of acutely sick children. The first chapters of the book are devoted to a discussion of the physiology of water and electrolyte metabolism and are written in an understandable manner. The second section of the book is devoted to a discussion of such conditions as diarrhea, diabetic coma, and fluid therapy in nonobstructive vomiting. These conditions are seen very frequently by the general practitioner and are also explained in an easily understandable manner. The importance of fluid therapy in surgical conditions and in burns is treated in a most concise manner and it is the opinion of this reviewer, that this is a "must" for the general practitioner who takes care of most of the surgical conditions and sees most of the children with severe burns. Section three deals with technical procedures of obtaining blood specimens and the techniques for the parenteral fluid administration. These procedures, while well understood by the general practitioner, are well covered in this book and very worthy of a review by men doing general work. Many of the conditions discussed are interspersed with case reports and all of these are excellently covered.

In short, here is a book which once picked up is hard to lay down and the reading of which is an excellent way of passing a long winter evening. The printing, paper, illustrations, and general make-up of the volume are done in the usual excellent manner of the publisher. This reviewer feels that this book is a "must" for the general practitioner. J.O.E.

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NEW AND NONOFFICIAL REMEDIES Issued under direction and supervision of the Council on Pharmacy and Chemistry, American Medical Association. $3.35. J. B. Lippincott Company, Philadelphia and Montreal, 1955.

New and Nonofficial Remedies is published annually under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association and contains descriptions of the articles which stand accepted by the Council on the first of the year.

Drugs added to the approved list during the past year are listed in the book with pertinent data to show the physician their composition, physical properties, dosage and indications. A number of drugs which appeared in the 1954 issue, have

(*Continued on page* 48)

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*1. Eisfelder, H.W.: Am. Pract. & Dig. Treat., 5:778 (Oct., 1954).*

*2. Sebrell, W.H., Jr.: J.A.M.A., 152:42 (May, 1953).*

*3. Sherman, R.J.: Medical Times, 82:107 (Feb., 1954).*


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## BOOK REVIEWS (Continued)

been omitted in the 1955 edition as they are considered either sufficiently well known, or they are no longer considered useful by the Council.

When we consider the personnel of the Council on Pharmacy and Chemistry and the long list of consultants who provided assistance to the Council and its Committees during the past year, it seems quite obvious that the drugs listed in the current issues are indeed well recommended.

The cost of this interesting book is nominal and it should be available in the library of all practitioners of medicine.

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Clinical Pathologic Conferences of Cook County Hospital Vol. I; Cardiovascular-Renal Problems. Editors: Hans Popper, M.D., Ph.D. Director, Department of Pathology, Cook County Hospital Scientific Director, Hektoen Institute for Medical Research of the Cook County Hospital; Associate Professor of Pathology, Northwestern University Medical School. Daniel S. Kushner, M.D. Associate Director of Medical Education, Cook County Hospital; Research Associate, Hektoen Institute for Medical Research of the Cook County Hospital; Clinical Assistant in Medicine and Fellow in Pathology, Northwestern University Medical School. The Blakiston Co., Inc., New York, 1954. $5.00.

The use of a Clinical Pathologic Conference as a teaching method is a more or less American custom dating back to those held by Richard C. Cabot in the early part of this century. The Cook County Hospital has an enviable tradition of such conferences conducted by men such as Fenger, Hektoen, Le Count, and Jaffé. Dr. Popper is a worthy member of this group. To attend one of his Clinical Pathological Conferences is an experience long remembered by medical students, interns, and residents. This book consists of a collection of interesting clinical pathological conferences with special attention to cardiovascular-renal problems. Case discussions are reported about as they actually occurred and their content is excellent. References are abundant. Some of the photographs appear to have suffered in the process of reproduction. This is a good book for anyone interested in clinical-pathological correlation of disease.




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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

REFRESHER COURSE FOR PRACTITIONERS. Specially contributed articles from the Journal of the Indian Medical Association. Volume 1. Journal of the Indian Medical Association, 23, Samayaya Mansions, Calcutta 13, India.

THE BILIARY TRACT. With special reference to the common bile duct. By Julian A. Sterling, A. B., M. D., M. Med. Sc., Sc. D., F. A. C. S. The Williams & Wilkins Company, Baltimore, 1955. $10.00.

THE AMERICAN DRUG INDEX. By Charles O. Wilson, Ph. D., Professor of Pharmaceutical Chemistry, College of Pharmacy, University of Texas, and Tony Everett Jones, M. D., Instructor of Pharmaceutical Chemistry, College of Pharmacy, University of Colorado, Director of Pharmaceutical Research, Carbisulphoil Company. J. B. Lippincott Company, Philadelphia and Montreal. $5.00.

VASCULAR SURGERY. Edited by Daniel C. Elin, M. D. and Michael E. DeBakey, M. D. Medical Department, United States Army, Surgery in World War II. Office of the Surgeon General, Department of the Army, Washington, D. C., 1955.

## The results are good

Experience with 105 consecutive cases of sympathectomy for peripheral vascular insufficiency of the lower extremities has been summarized. There were no operative deaths. Postoperative morbidity has been inconsequential. Results have been excellent or good in 62.5 per cent of overall cases. Results have been excellent or good in 70 per cent of arteriosclerotics; in 78 per cent of arteriosclerotics with gangrene; in 66 per cent of cases with frostbite; and in 80 per cent of the cases of Leriche's syndrome. Results of sympathectomy in thromboangiitis obliterans have been disappointing. The clinical course of chronic thrombophlebitis attended by peripheral vascular insufficiency has not been materially influenced by sympathectomy in our experience. The lumbar sympathetic ganglion block was of little value in selecting cases for sympathectomy. Sympathectomy is contraindicated principally by the presence of primary arteriolar disease. *William G. Eckman, Jr., M. D., Lumbar Sympathectomy in Treatment of Peripheral Vascular Insufficiency. Ohio M.J. Dec. 1955.*

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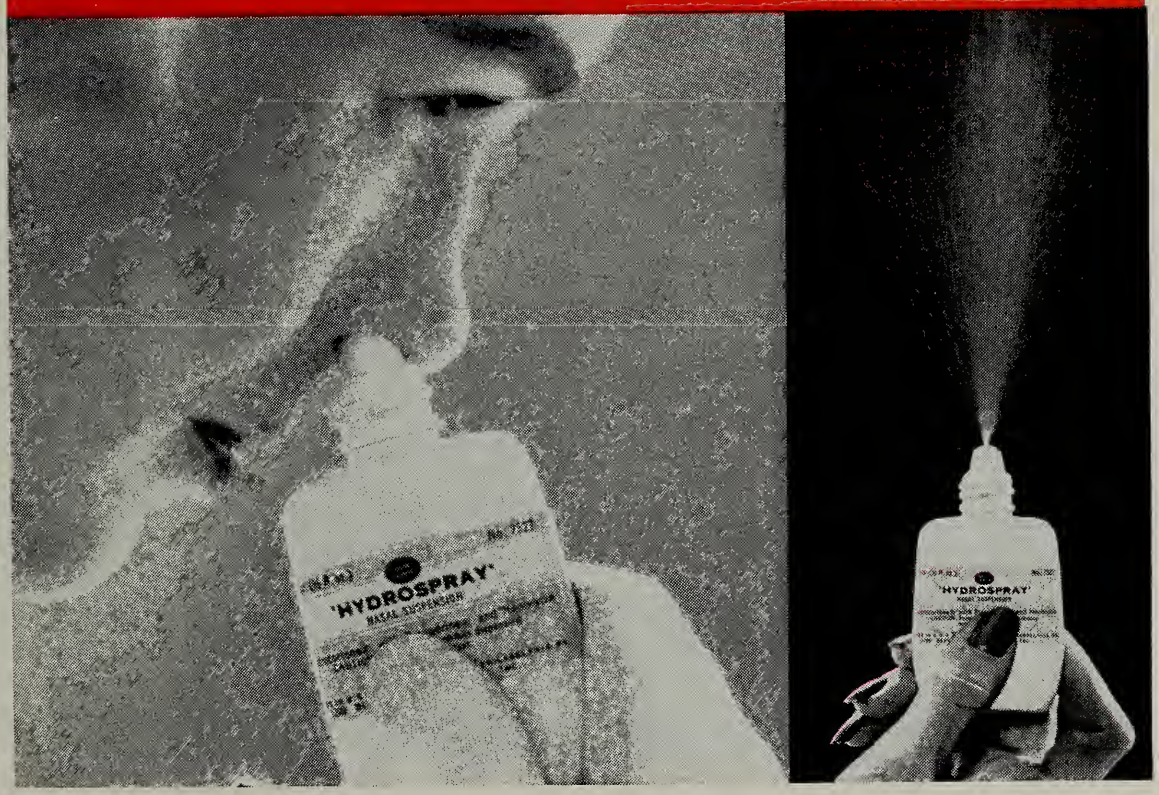
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**REFERENCE:** 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* **60**:431, Oct. 1954.

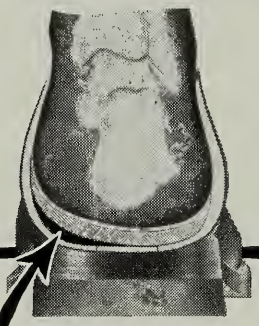
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## Focal infection

We used to think that rheumatoid arthritis had some relation to focal infections because so many focal infections had streptococci in them. But later it was demonstrated that streptococci were in everybody's mouth and did not mean so much. It was found also that focal infection had nothing much to do with rheumatoid arthritis. That rather weakened the whole streptococcus theory which had been built up by Dr. Rosenow and others of the focal infection school. I grew up in the old school of physicians who never tired of talking about infected tonsils and teeth. The only evidence we have is the fact that 50 to 75 per cent of patients, depending upon the duration of the disease, will show a definite and highly specific agglutination in their serum with hemolytic streptococci. *Russell L. Cecil, M.D. Rheumatoid Arthritis. New York Med. Sept. 5, 1955.*

‹ ›

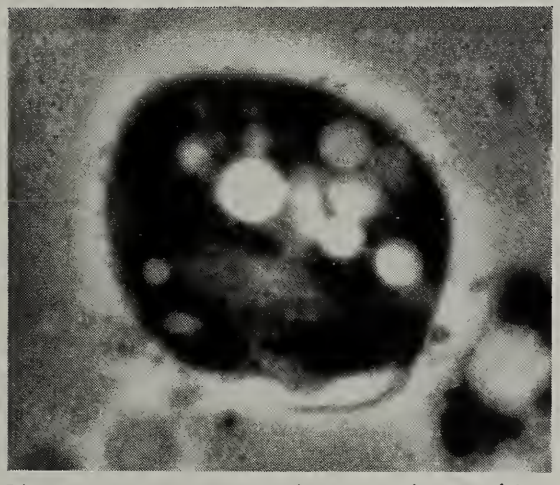
## "Doctor, it's my nerves"

Psychosomatic illness is a situation wherein the patient's subjective discomforts are referable to his physical self, although they are of psychic origin. The psychosomatic response occurs normally in the form of the blush on embarrassment, a rapid heart on excitement, and many others, but this is not a disease. However, when the physical sensation associated with response to the emotions causes complaint or results in structural change, then there is psychosomatic illness. Note that this definition ignores mechanism and stresses physical manifestation of emotional origin, regardless of mechanism. *James B. McLester, M.D. The Patient's Attitude Toward his Disease in Psychosomatic Illness. J.M.A. Alabama, Sept. 1955.*

‹ ›

By handicapping their victims without killing them, chronic diseases have come to constitute a huge financial and emotional problem—ever increasing in size—which threatens to choke the medical economy of our communities. It is folly to regard them as solved medically until they have been eradicated . . . It is obvious that the most direct approach to the eradication of tuberculosis is to prevent tubercle bacilli from reaching human beings. Rene J. Dubos, Ph.D., Nat. Tuberc. A. Tr., May, 1954.

# DAVIS TECHNIC USING VAGISEC* JELLY AND LIQUID EXPOSES AND EXPLODES TRICHOMONADS HIDDEN AWAY IN RUGAE



*Phase-contrast microscope shows a trichomonad in a mucinous vaginal smear.*

MANY trichomonacides failed in years past largely because they reached only the parasites swimming freely in the vaginal canal—not those hiding under epithelial cells deep among the vaginal rugae. In fact, some agents actually coagulated the albuminous material lining the surface and protected the trichomonads![1]

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*The Davis technic.*† Dr. Davis recommends a combination of office treatments and home treatments, using both VAGISEC jelly and liquid in home treatments. "A few women have infected cervical, vestibular or urethral glands and require other types of treatment. . . ."[2] It is well to remember the role of the male as carrier of the organism and prescribe protection against re-infection from the husband.[2]

*Office treatment.* Expose vagina with speculum. Wipe walls dry with cotton sponges and wash thoroughly for about three minutes with a 1:250 dilution of VAGISEC liquid. Remove excess fluid with cotton sponges. Dr. Davis recommends six office treatments, three the first week, two the second, and one the third.

*Home treatment.* Patient inserts VAGISEC jelly each night and douches with VAGISEC liquid (2 teaspoonfuls in 2 quarts of warm water) each morning except on office treatment days, through two menstrual periods. Continued douching two or three times a week helps to prevent re-infection. Pregnant women should have office treatments only.

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1. Davis, C. H.: Am. Jour. Obst. & Gynec. *68*:559 (Aug.) 1954.
2. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955.
3. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955.

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## A complicated cause for bleeding

The exact cause of functional uterine bleeding remains obscure. The abnormal fluctuations of estrogen levels usually are the immediate but not the underlying cause. Apparently the levels of both estrogen and progesterone in the blood control the release of pituitary gonadotrophins, thereby effecting a reciprocal hypophyseal-ovarian relationship. Obviously, other glands are involved. The thyroid is in some fashion functionally linked with the gonads but the exact mechanism involved is not clearly understood. It is thought that the influence of the thyroid gland on the ovary may be mediated through the pituitary. At any rate, the sex endocrine cycle is labile and may react to many factors in the soma. *William C. Pallas, M.D. Abnormal Uterine Bleeding. J. Tennessee M.A. Oct. 1955.*

‹ ›

## Ovarian tumor

A full bladder, a distended cecum, or contents of the lower bowel may be confused with an ovarian tumor. In addition to the normal contents of these structures, adrenal, bowel, or bladder tumors and intussusception all may give symptoms and signs suggestive of ovarian tumor. These structures should be evaluated carefully prior to any surgical exploration for ovarian tumor. *John Parks, M.D. Management of Ovarian Tumors. J. Oklahoma M.A. Oct. 1955.*

‹ ›

The present favorable situation with respect to tuberculosis mortality is the result of modern case-finding techniques, developed some years ago and applied intensively since 1945; and it is the result of tremendous advances in the chemotherapy of tuberculosis. Leonard A. Scheele, M.D., Bull. Nat. Tuberc. A., May, 1955.

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## Gray hairs of the intestine

A significant percentage of the population over 45 have diverticula of the colon but fortunately only a small percentage have trouble at an older age. Acute inflammation is the usual situation and these people are usually sicker than those with acute appendicitis. They have fever and often are quite toxic. If one is confronted with this situation and it does not respond to the administration of antibiotics and other supportive measures, early proximal colostomy is a worthwhile procedure. By diverting the fecal stream the bowel is put at rest and dramatic improvement often ensues. If there are signs of intraperitoneal abscess, this should be drained. Ideally one likes to defer surgical intervention in patients with diverticulitis because relatively little can be done as far as the local situation is concerned. But if symptoms progress and the patient is extremely toxic, colostomy is indicated. *Howard S. Madigan, M.D. Emergency Surgery in the Aged. New York J. Med. Oct. 15, 1955.*

## The urogram

The most important urologic procedure to uncover asymptomatic renal disease or to reveal whether the problem is surgical or medical, is an intravenous urogram. In our experience this supersedes the history, physical examination, and many times the urinalysis. It is our conviction that if more hidden renal disease is to be revealed, in the event a patient has vague abdominal complaints, the procedure is to do an intravenous urogram rather than repeated urinalyses. We would strongly urge the adoption of a routine kidney-ureter-bladder roentgenogram, regardless of the patient's complaints, as part of a physical examination. The expense involved is not great when one considers the information derived. This would uncover a large number of asymptomatic lesions (progressive asymptomatic hydronephrosis, calculi, cysts, and retroperitoneal tumors). *Monroe E. Greenberger, M.D. et al. Atypical Symptoms with Underlying Urologic Disease. New York J. Med. Oct. 15, 1955.*


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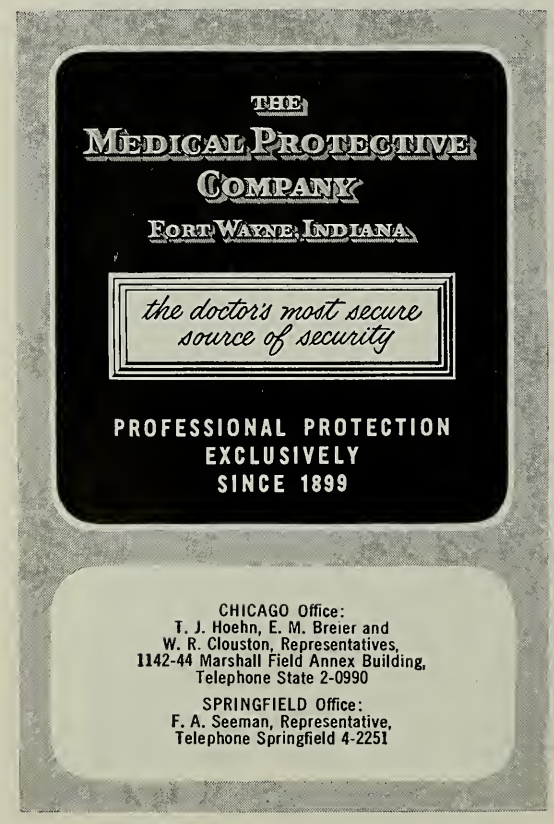
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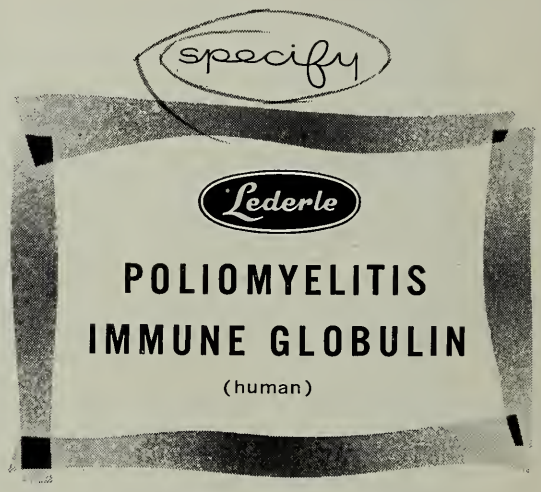

## The dreamer

It has been shown that the blood oxygen level fluctuates exactly as the normal person's awareness, dropping to its lowest point in deep sleep and reaching its height during an attention peak. This in no way proves a cause and effect relationship. Furthermore, schizophrenics have blood oxygen levels equal approximately to a sleeper's, lending support to Jung's description of the schizophrenic: "A dreamer in a world awake." Respirations are slower, more irregular and periodic, and more intercostal during sleep. Bodily secretions, with the exception of sweat, are generally depressed in sleep. Tears decrease at the time of day when we normally prepare for sleep, causing one to rub one's eyes and thus giving biologic support to the legendary sandman. *Robert J. Carey, M.D. Sleep. Boston Med. Quart. June 1955.*

‹ ›

X-ray screening for unsuspected thoracic disease cannot fail to enhance the general hospital's prestige, both as a center for modern medical care and as a community resource for better health and longer life. Theodore L. Badger, M. D., Bull. Nat. Tuberc. A., June, 1955.


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He will always be a slave who does not know how to live upon a little. —Horace


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Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.




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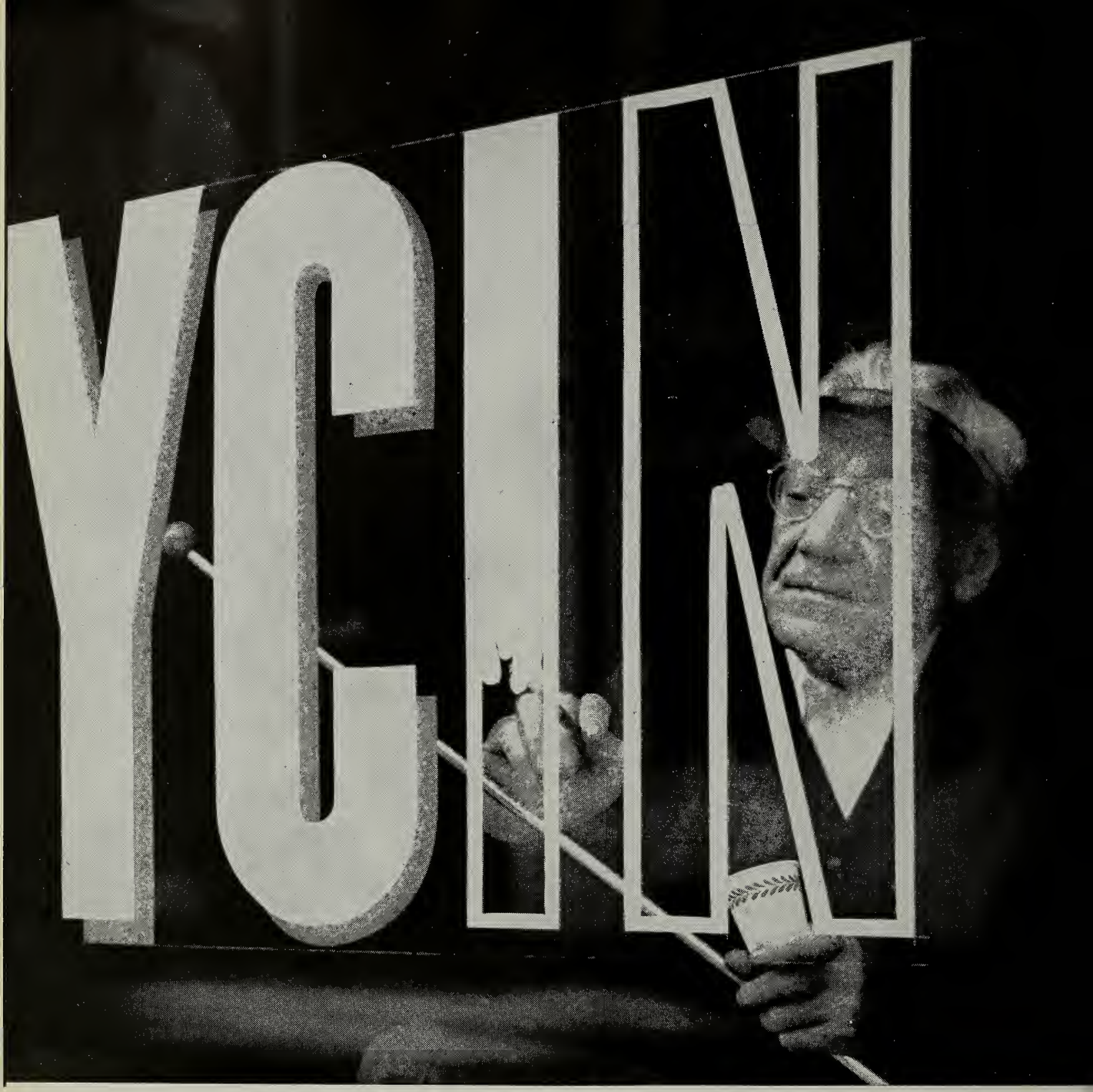
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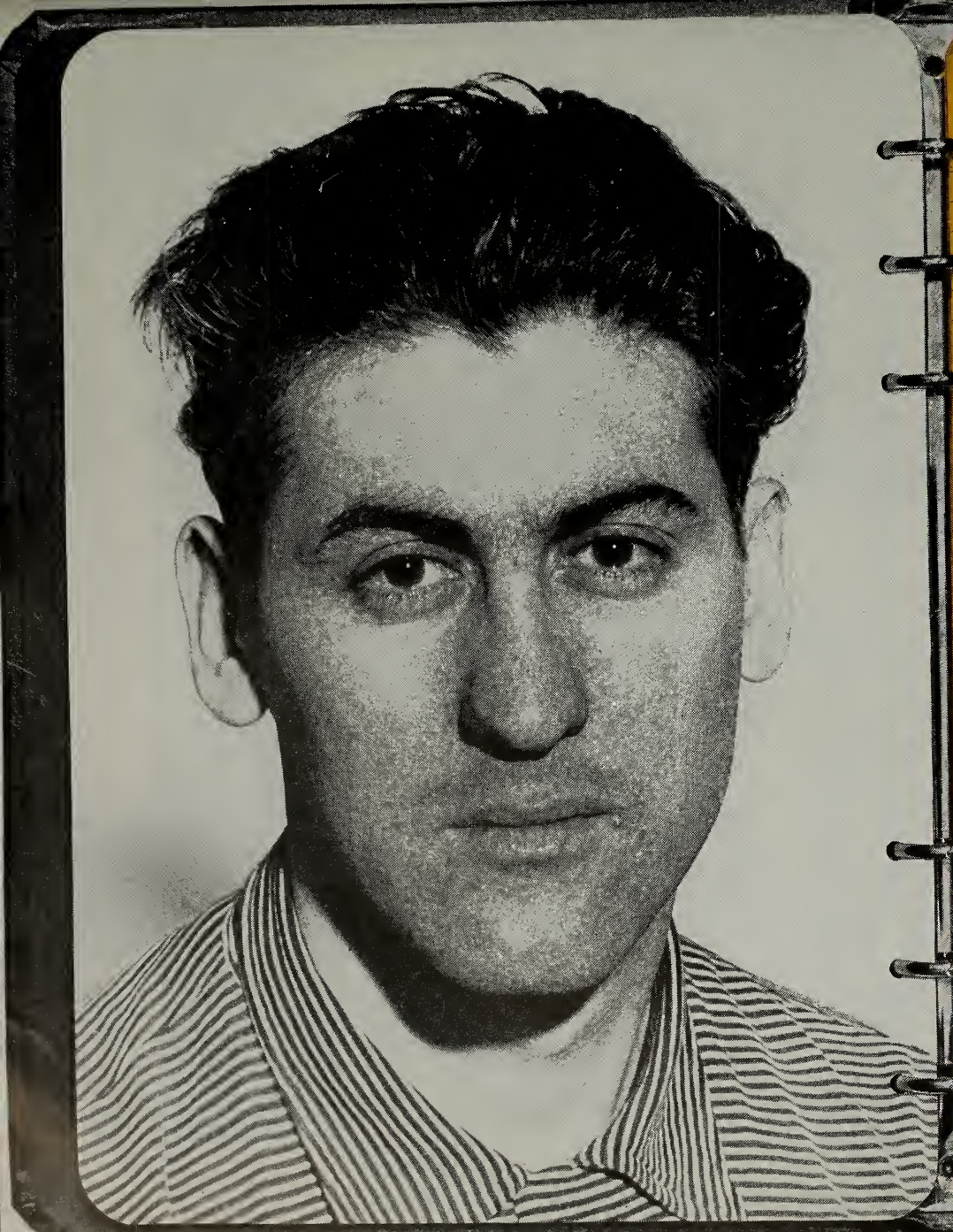


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This list is correct in accordance with the best information obtainable at the date of going to press. County Secretaries are requested to notify The Journal of any changes or errors.

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Continued on Page 14



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Sex: Male Age: 38 Occupation: Railroad engineer

Chief Complaint: fatigue, anorexia, sleeplessness.

Symptoms: fast pulse, restless movements, nervous speech habits.

Observations: bouts of depression and discouragement seemed to date from time of release from military service, recurring when work became heavy.

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Response: felt fine, good spirits, appetite excellent, pulse down from 112 to 84.

Results: Improved – no signs or symptoms of original complaint.

Overworked, Depressed

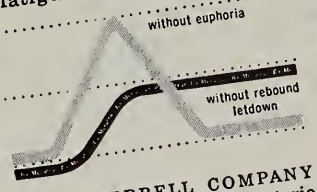

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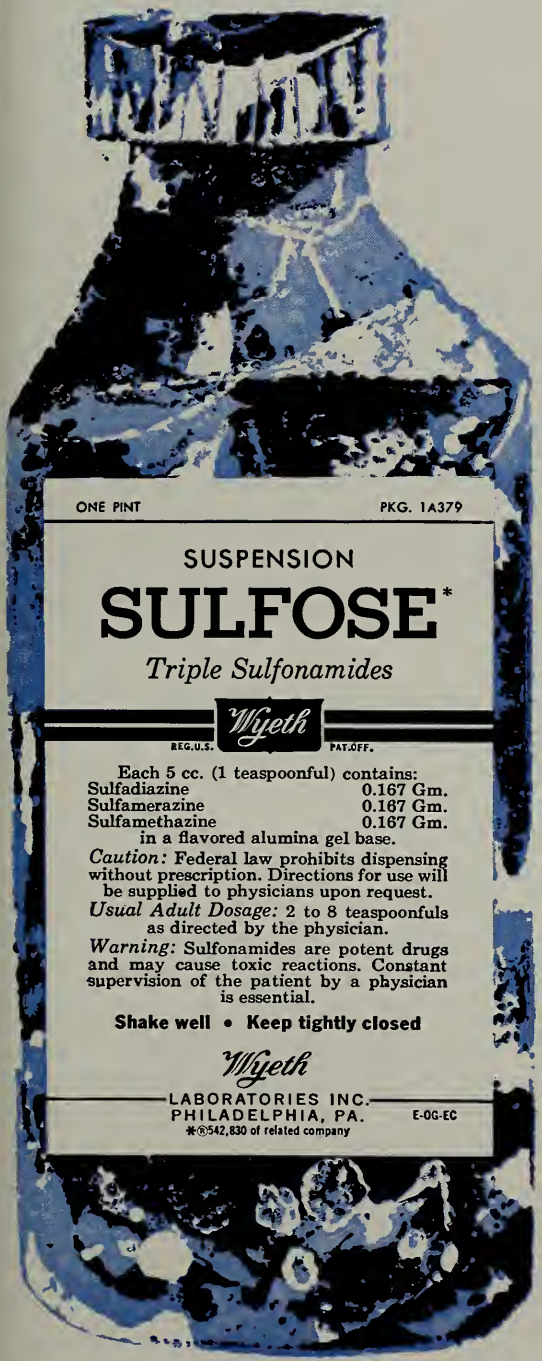
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# The Month in Washington

Washington, D.C.—All too frequently overlooked in Congressional activity on health and related bills each year are the little-publicized but highly important appropriations measures — without which no program of the federal government could move forward. The appropriations hearings in the House (where all money bills must originate) rarely get headlines they are conducted behind closed doors. Weeks and some times months later, the hearings are published, but by then the bill supplying money for an agency has been reported to the House.

It's only when the measure gets to the Senate that private groups and individuals are heard — by then in open sessions. Closed House sessions are not new. That is the way it has been done ever since Congress set up a separate committee on appropriations back in 1865.

The importance of appropriations in running the federal government was clearly illustrated when the President submitted to Congress his 1,272-page budget message in which he sought $65.9 billion for all federal programs for the fiscal year beginning July 1.

While there was no overall total of projected spending by all the agencies in the health field, the budget requests for the Department of Health, Education, and Welfare showed a sharply upward trend. And if certain new legislation is voted on this session — like the projected 5-year program of construction grants for medical schools and private laboratory facilities — the total figure for subsequent years is likely to be even higher.

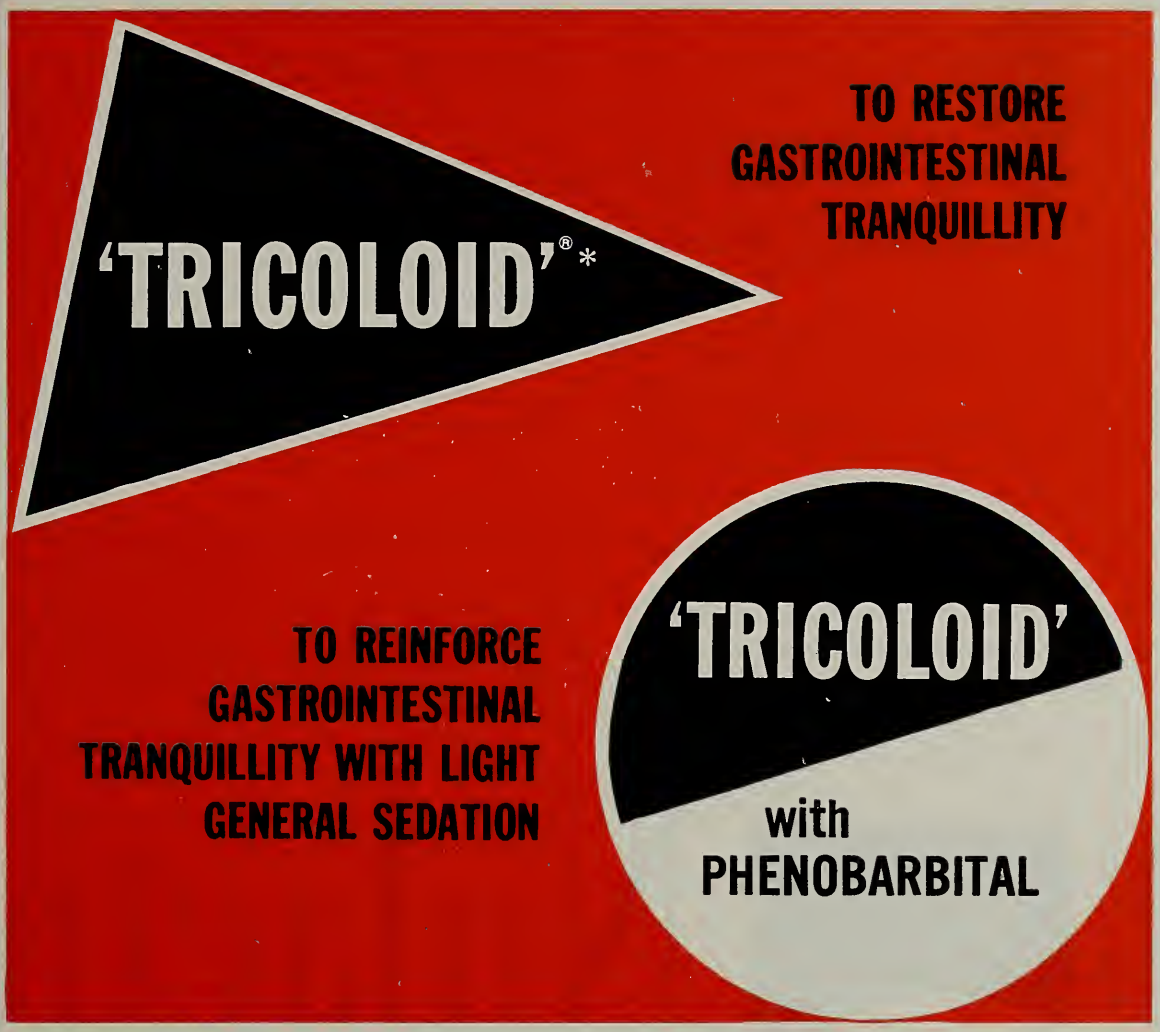
On the medical school-laboratory construction bill, the President asked Congress for $40 million for the first year (estimated cost over five years is $250 million). Construction grants, which would have to be matched on a 50-50 basis, would be available for private medical schools as well as non-federal laboratories conducting research into a wide range of crippling diseases.

The budget message also calls for another $30 million in outright grants, to the states to help them in financing poliomyelitis vaccination programs, the same amount appropriated by Congress last session. The administration in a separate request asked for extension of the polio law, from February 15, 1956 to June 30, 1957, and both the House and Senate with only brief debate voted the 17-month extension. Since only half of last year's $30 million was spent up to the February 15 expiration date of the original act, there was no rush for Congress to act on the new account.

Other new spending asked by the administration, contingent, of course, on enabling legislation, includes $10 million for initial capitalization of mortgage loan guarantees for health facilities; $5 million for graduate and practical nurse and professional health personnel training, $3 million for water pollution grants; $1.5 million for mental health expansion programs; and $1 million for sickness and disability surveys in the U. S.

If Congress approves the requests, virtually all segments of the Department of HEW will have more money to spend than in this fiscal year. None would benefit more, however, than

(*Continued on page* 34)




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**WASHINGTON (Continued)**

the medical research arm of government, the National Institutes of Health. The total sought for the seven institutes is 28% more than estimated spending this year. Here are some examples: National Cancer Institute, $32,437,000, up 29%; National Heart Institute, $22,106,000, up 17%, and the National Institutte of Allergy and Infectious Diseases (formerly the National Microbiological Institute), $9,799,000, a 26% increase.

The President requested $130 million for the Hill-Burton hospital-clinic construction program which will be 10 years old this August. In this connection Congress has been asked to extend the act for two years beyond next year, and action is expected this session.

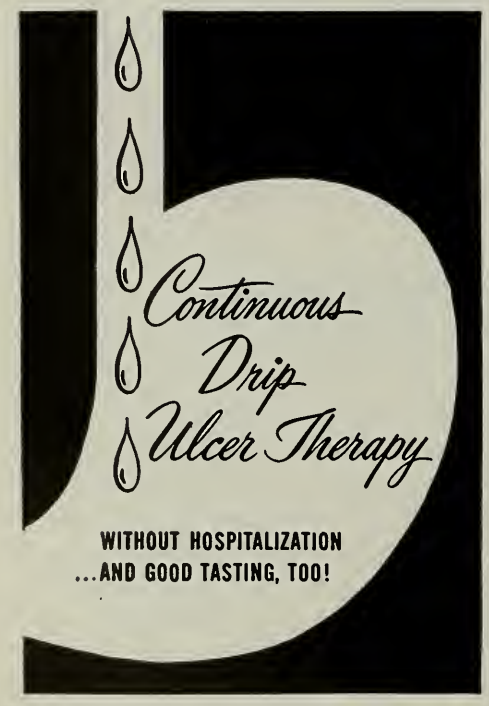
*NOTES*:

After a study of possibilities in the peaceful uses of atomic energy, a panel has recommended, among other things, that the U.S. encourage states and private organizations to take full advantages of the opportunities offered by radioactive material for medical research and treatment.

It now appears that an improved and more uniform program of medical care for service families will be adopted this session—possibly before this is published. One feature: A $25 deductible charge in civilian hospitals, but with the government paying the full insurance premium, and a mandatory subsistence charge in military hospitals.

Making slower progress is the plan — under consideration for more than a year — for a health insurance program for U.S. civilian workers. Here the government would pay about half the cost.

Several committees are urging stricter penalties and other changes to bring the illicit narcotic traffic under better control; so far suggestion of more controls over the medical profession in the handling of narcotics.


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# Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

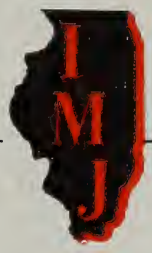
The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

The
ILLINOIS
Medical Journal




**Official Journal of The Illinois State Medical Society**

MARCH, 1956
VOL. 109 NO. 3

# The Danger of Delay

**William Benbow Thompson, M.D., Los Angeles, California**

IN 1937, my associate, Emil J. Krahulik, and I[1] reported an analysis of 135 deaths after cesarean section gathered from the seven cities survey[2] and from Los Angeles County. In 1947[3] we reported an additional 75 deaths. These reports seem to have been the first considerations exclusively dealing with cesarean fatalities, and were followed, in 1951, by Gordon's[4] remarkable collection of 258 deaths in Brooklyn and environs. The three reports had several points of similarity, but none more striking than the fact that the most frequent error of judgment was delay. In this discussion, I shall endeavor to point out some delays that have added hazards to the inherent dangers of childbirth, and to suggest how they may be avoided.

Delay as a danger was first noted by us in association with abdominal delivery. Certainly this is not the only field in which this phenomenon is manifest but since our attention was aroused by failures to recognize and treat promptly some of the complications of pregnancy and labor in which cesarean section was appropriate, I shall consider first some instances wherein delay increases the risks involved in this procedure.

One of the great hazards to successful delivery is an inefficient uterus that fails to produce rhythmic forcible contractions in sequence. While attempts are made sporadically to prognosticate the outcome on the basis of configuration, degree of fat deposits, and other factors of some diagnostic value, the sad fact remains that the only criteria of importance arise when the patient actually is in labor. Then, and only then, can the pattern of labor be correlated with the probabilities of the future. When contractions are intermittent, fitful, and serve only to keep the patient awake and uncomfortable, the attendant should take heed. When this indifferent semi-labor continues for 12 to 18 hours without altering appreciably dilatation or descent of presenting part, then the attendant should be warned.

This is no the time for him to reason "She'll go into active labor presently, and the nurse will call me." Hence 24 to 36 hours elapse before he even starts to consider alternative procedures. And the vicious chain of circumstances continues. Now a new day is at hand, with house calls, office appointments, meetings, and all the daily duties. It is so easy to continue the usual round because "my patient is not doing anything" — except wasting her strength and her resistance. Eventually she may deliver, as witness the extensive bibliography on prolonged labor. Note, however, that these articles on long labors invariably relate a considerably increased

*Presented before General Assembly, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

fetal loss and an increased percentage of these unfortunates ultimately reach the operating rooms.

I would not for an instant wish to give the impression that I have a magic formula whereby this problem is solved. All I can do is to suggest that wishful thinking be replaced by careful consideration of the patient's needs. This cannot be secured by any routine to be applied by the nursing or house staff. It calls for closer personal supervision than is needed by patients progressing normally. These girls are discouraged. No one need tell them that they are "not doing anything". They know it, and their spirits are low. I admit a number of rather violent prejudices, of which amateur hypnosis is one, but here is where sympathetic suggestion often is worth a trial. If you can soothe the apprehensions of one of these patients and substitute relaxation for her tensions born of fears, you will have made a real contribution to her reserves. This must be done early, not after long hours of weariness have conditioned her mind and body to resist to the last the trials that beset her. I dislike pitocin drip infusions and fear they are being used too often for too many patients but in the presence of a labor that has indicated sluggishness in the first eight or 10 hours, I will use this agent in a highly diluted form, but only if I am present. It is a powerful stimulant and administration should not be delegated to some youngster, even though this may increase his experience. Let him stand with you at the bedside if you will, but it is your responsibility to maintain a minimal safe dosage.

But what if suggestion and moral support be not enough, and the artificially stimulated activity of the uterus still fails to indicate promise for the future? I assume that fluid balance has been maintained and even that nature's resistance to intrapartum infection has been augmented by the use of one or more of the antibiotics. I assume further that 18 to 24 hours of ineffectual labor have dragged along. Here I take issue with the so-called conservatives. I believe wholeheartedly that, in the absence of any indication that the dismal picture will shortly brighten, fewer risks are assumed by performing a low cervical cesarean at this point than by further procrastination.

Granted, by another day it might still be possible to deliver the patient by extraperitoneal section. Granted, it might be possible to avoid peritonitis if that layer remains vital and intact, and to reduce the incidence of wound infection with antibiotics. And granted, some of these patients would deliver vaginally if their strength held out until they had literally slugged their passenger through the birth canal. It still would be true, however, that in this extra 24 hours a number of babies would be lost, and a number of patients would have prolonged, expensive convalescences. Hence I believe that, despite the increase in the incidence of operative delivery, one should not allow himself more than 24 hours to predict the outcome of labor, and that he should then proceed with definitive action when the prospects appear dim.

Turn now to another complication affecting delivery in which delay in providing remedial care may be hazardous and in which the time spent in confirming a diagnosis may militate against the best interest of the patient. Hemorrhage at or near term usually betokens either placenta praevia or premature separation of the placenta. Which confronts you? For that matter if bleeding be profuse, what difference does it make? The usual story is that the patient or her husband phones that she is bleeding severely. An ambulance is hurried to the home and hurries back to the hospital with screaming of sirens and ringing of bells. On arriving in the delivery suite, the attendant confirms the fact that the patient really is bleeding. There are pads and towels to attest this item, although the patient invariably overestimates the total amount so displayed.

An additional yardstick is noted by Parks. If the bleeding began in the early morning, as is frequent, one may find feet stained with blood. This he considers an indication of a blood loss of at least 250 cc. The patient may sponge away blood on her thighs and vulva but close to term she cannot easily cleanse her feet. So one comes to a logical conclusion. This patient has lost a sizable amount of blood. Her immediate condition, and whether the bleeding is continuing, should determine whether diagnosis or treatment should be attempted first.

All too often, once the patient has reached the delivery suite, action seems to cease. A lab technician leisurely appears and draws blood for typing and cross-matching since the hospital will not accept the typing made previously by another

laboratory. At least half an hour, and more commonly an hour or more, elapses before blood is certified as being compatible. X-ray of the abdomen to determine placental location may be essayed, but the roentgenologist hesitates to render an opinion on a wet plate. A sterile vaginal examination, as stressed by practically all our professors, hauls the patient from her bed to the operating table and back again. The clock races merrily along.

Provided the bleeding is checked or is not continuing at a brisk pace, these steps can proceed without endangering the patient's chances but, except for the blood matching, they have no place in the management of severe hemorrhage. Prompt replacement of blood loss is imperative and no well organized obstetrical department should be without a reasonable quantity of prepared O-negative blood for such emergencies. But promptness in conserving the patient's own blood is equally important. Delay means additional blood loss which in turn means additional danger.

The differentiation between placenta praevia and premature placental separation is not always simple. Separations are not always accompanied by rigid uteri, and pain is not always present. Several years ago, I encountered three instances in a row where the symptoms seemed classic for placenta praevia, and all three were placental separations high in the fundus. Neither do the lesser degrees of encroachment upon the lower segment in placenta praevia always show less marked hemorrhage.

The first contribution to[5] medical literature bearing my name included a fine illustration by Max Bröedl of a postmortem uterus showing a marginal placenta praevia in which the area of separation was not over ten square centimeters but from which the patient died of hemorrhage. What I am trying to emphasize is that the course of action should be dependent upon blood loss, rather than upon diagnosis. It is all very nice to specify "38 weeks of pregnancy. Hemorrhage due to placenta praevia" as the preoperative indication and then have that opinion confirmed on the operating table, but it may not be safe to spend the time necessary to be sure of the diagnosis. Promptness in checking the open sinuses from which vital fluid is pouring is more valuable than the refinements of diagnosis. I do not exclude vaginal examination from the list of time-consuming, unnecessary procedures. At best, it will average an additional twenty minutes during which the bleeding continues.

Recently there has been some controversy as to whether "once a cesarean, always a cesarean" should hold its place among the classic dicta. I contend that it should. There are those who suggest, because cesarean mortalities commonly are higher than vaginal deliveries, merely electing the vaginal route in the previous cesarean patient will place her in the safer category. I don't believe it. Those who have tried this experiment have stressed that constant attention is needed, and that operating facilities must constantly be available.

This statement alone belies their contention. If vaginal delivery be safer, as they insist, then why the need for a standby operating room, complete with nurses and anesthetist? I admit that such provision is wise since these reports all show some ruptured uteri. It is significant, I think, that these uteri ruptured in spite of the close supervision of the labors to which they were subjected. Thus far, no signs and symptoms have been proposed that indicate solidity of the uterine scar. All of the findings and suggestions have been aimed at early detection of impending rupture and to date, none has proved more significant than the presence or absence of pain in the scar area.

As to the safety provision of an operating room and staff in constant readiness, what patient could today assume that financial load even if the hospital were willing so to tie up its working space? Robert Cosgrove[6], attempting to answer this question at the 1950 A. M. A. session, stated that doctors should have more to say in hospital management and insist upon this and similar safeguards for their patients at no additional charge. In the Margaret Hague, the Cosgroves may dictate as they wish but even there hospital costs depend upon hospital usage. Even in charitable institutions, nurses and anesthetists are paid and costs mount up whether or not assessed directly to the patient. In a private hospital these charges would be fantastic. On economic grounds alone, then, it is not feasible to deliver a precious cesarean patient from below.

What are the dangers of repeated cesareans? Arnot[7] pointed out long ago that the repeat

cesarean was safer than the initial operation. At the Cedars of Lebanon Hospital[8] where previous cesarean is an accepted indication, nearly 1,200 repeat operations have been done since the opening of the hospital in 1930, thus far without a death. In fact, the overall cesarean mortality, including the poor risks, is lower than for all deliveries. Tollefson[9] has just published the statistics from the California Hospital at Los Angeles, again without a death in 612 of the repeat groups.

A point emphasized by those who favor vaginal delivery after sections is that there is not thus an artificial limitation of the size of the family. Not too long ago the papers reported an instance of one patient who had had eight cesareans at one hospital, done by the same physician, possibly on a job lot basis. At the forthcoming A.M.A. session is listed a discussion by McNally of Baltimore on "The Patient with Four or More Cesarean Sections". Thus concern over limitation of the number of offspring by repeated cesarean would seem to have little basis in fact. Hence, I still insist that with this condition there is more danger in delay than in the procedure.

It would seem that I am advocating extension of the indications for cesarean, with an attendant increased incidence. That is true. Cesarean mortality tables tend to exaggerate the dangers of the operation dealing as they do with patients depleted of resistance by long, tedious labors, with excessive blood loss, and with nephritis, diabetes, or other systemic disorders. Such patients are poor risks. The point to be held in mind is that they are even poorer risks for vaginal delivery.

We must accept the systemic diseases complicating pregnancy as they come, and do our best to carry these women through the valley of the shadow. At the same time, we should endeavor to give patients afflicted with prolonged labors and debilitating hemorrhages the benefit of the safest mode of delivery at our command. Cesarean may be the answer provided one has not delayed until the period of safety has elapsed. The operation itself is not technically too difficult. The chief demand upon one's judgment is the time at which it is done.

Consider for a moment older procedures that were employed when cesareans were actually unsafe. How many of you would now do Dührssen's incisions and a midforcepts delivery? How many of you would be now satisfied that you had exercised excellent obstetrical judgment when by so doing you had as a result a more or less damaged baby and a vaginal cripple even though her abdomen was unsullied by a scar? In my hospital days, the indication for a simple low forceps was two hours of labor without advance or, as a teaching indication, after an hour. Doesn't that seem archaic to you now? It does to me. Isn't it just as archaic to postpone a cesarean section because of time-hallowed fears of its dangers? Nonetheless, powerful forces residing in Chicago damn a hospital whose cesarean rate is above 4%.

It is somewhat paradoxical that hemorrhage heads the list of factors involved in maternal mortality although blood is currently available in all our major hospitals, and even in small communities, "walking blood banks" are maintained. Delay in the giving of blood is not now often noted in surgical procedures if these be on the operating lists. In the delivery room, however, this is often unavoidable. Not many births can be scheduled in advance; hence not often will one realize the need for typing and cross-matching before blood loss occurs. This state of affairs can be improved considerably by following the rules recently detailed by Gaspar[10] which included placing an 18 gauge needle in the veins of patients with twins or hydramnios, or who have had either overlong or overshort labors, or who have a history of postpartum hemorrhage. Promptness in transfusion when needed can and does save lives.

There will arise in the course of an obstetrical lifetime a few cases of seemingly intractable postpartum hemorrhage. Bleeding continues at an excessive rate or, with momentary checking of external evidence, resumes its flow when the uterus and vagina are emptied of clots. My most recent experience with such a patient was only a year and a half ago. This patient began bleeding profusely three hours after delivery. There was only transient response to oxytoics. (Parenthetically, I have gained the impression that if there is not firm and continued contraction of the uterus with the first injection of an ergot preparation, there will be no better contraction with repeated doses. I continue such medica-

tion and will continue so to do, but I begin my active worrying with such an initial failure of result.)

Transfusion was started at once, and shortly a second vein was employed. Blood was run in under pressure and even then we were able to maintain blood pressure at only shock levels of 50-70/20-20. At the end of an hour, having given 2000 cc. of blood, I did a rapid hysterectomy. With the clamping of the second uterine artery, pressure rose to 110/60, and was maintained. All told this patient received 8 flasks of blood in 8 hours. It was harsh treatment. I didn't enjoy the decision to remove the uterus from a young girl who had just been delivered of her first baby but I would have enjoyed much less trying to explain her death to husband and family. I caution you, if faced with similar circumstances, do not delay radical intervention until the patient is in irreversible shock.

Thus far, we have been concerned chiefly with the parturient, but delay in care can be just as hazardous for the newborn. We all are aware that promptness in exchange transfusion is essential if Rh incompatibility is shown by a positive Coomb's test. We are forewarned of possible trouble and have made arrangements in advance to anticipate the problem. Our forebodings are not aroused, however, under more ordinary circumstances, and sometimes we fall into error.

The most important change in the transition from intra- to extra- uterine existence is the change in the method of oxygenation of the baby's blood. All manner of evils result when that transfer is not effected promptly. The baby's initial breathing is important. In the delivery room, usually the physician has nothing else demanding his attention for the moment and hence ordinarily he attends the child until he is squalling lustily, red of face, and safe into the world. If, however, the babe is born limp and listless whether from sedatives, anesthesia, or the trials of his passage through the birth canal, how well organized are the resuscitatory measures at hand? Even so simple a matter as placing a small catheter through the nose into the nasopharynx and bubbling oxygen through it will frequently maintain life and vitality. If the need for oxygenation is more urgent, intratracheal intubation is simple and the only certain method of supplying oxygen to the infantile alveolar balloons. Eastman[11] has pointed out in his beautiful essay "Mt. Everest in Utero" that the fetus has accustomed himself to an oxygen concentration lower than that at the dizzy heights of the world's loftiest peak but he cannot long exist outside his sheltered chrysalis without a much more abundant supply of this most vital gas.

Babies born by cesarean are less likely to survive than those delivered vaginally. Various explanations for this are suggested. Many infants have been adversely affected by toxemia of the mother or her loss of blood to the extent that her blood pressure is lowered, or more directly affected by premature separation of the placenta. An appreciable percentage are prematures, subject to all the hazards of immature life. Some are, I fear, victims of delay in clearing their breathing passages of fluids and mucus. Tollefson[9] believes that the babe is conditioned for breathing by the rhythmic compressions received during labor and that the compression of its chest in moving through the birth canal tends to clear the larger bronchi of their burden of fluid. If these hypotheses be true, what possible excuse have we at cesarean for handing the new born to the least skillful attendants at the operation? I have seen an interne or student nurse entrusted with the baby in whose interests the cesarean was done. Too often more expert care is not secured until long minutes of nonbreathing have convinced the tyro that his or her efforts were not enough.

There is little excuse for not assuring a cesarean babe of his best possible chance for survival. Our operating team means three men in attendance; the operator, the first assistant, and the man who drops out with the baby. If only two of us are available, one of the house staff serves as first assistant, and a senior man still is in charge of the babe until it is safely on its way to the nursery. I commend this arrangement to you. Delay in care of the cesarean newborn may negate the whole basis of a particular procedure to say nothing of the grief needlessly caused the mother.

Years ago a story was told, probably apocryphal, of a wise Chicago obstetrician who, when called in consultation because of difficulties in labor, would gallop his horse across town, dash into the hospital and up to the delivery suite, change hurriedly into a scrub suit, and then take from his coat a nice Havana cigar which he

would light and smoke leisurely until it would smoke no more. By the time the cigar was consumed, the problems of delivery were spontaneously resolved. He may have been wise for his day, but I fear his modern prototype does not deserve our respect and admiration.

There is a place for watching and studying, but not while facing conditions that demand promptness if they are to be alleviated. In our scrub room is a bronze plaque setting forth Bumm's aphorism "He who cannot await the safe processes of nature is no true obstetrician". But the emphasis is on safety, not merely waiting. Fellow physicians, watchful waiting is an excellent policy only if one knows for what he is watching and is not stupidly awaiting the occurrence of disaster. There are dangers in delay.


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## The treatment of rheumatoid arthritis

One of the biggest bugbears for practitioners has been the desire for a single form of treatment in rheumatoid arthritis that could be put to use as a routine measure for patients when the diagnosis is first made. If the physician understands the disease and knows the variations in management required in the different stages of illness and in the different patients, he can appreciate that no single treatment can be adequate even with the remarkable new discoveries that have been made. Any treatment program for a patient with rheumatoid arthritis requires attention to many different things. A single medicine given by mouth or injection, a single physical treatment, a single diet is inadequate. It is necessary to mold a program that has many facets to fit the patient's problem and to change this from time to time as the conditions change. It the physician appreciates these features of the patient who is ill with rheumatoid arthritis, he will do much better in planning treatment. *Richard H. Freyberg, M.D. Rheumatoid Arthritis. New York Med. Sept. 5, 1955.*

# The Diagnosis of Pulmonary Lesions

Noble Correll, Jr., M.D. and Hiram T. Langston, M.D., Hines

OFTEN and even after extensive study, the nature of a lung lesion may remain indeterminate unless tissue is obtained for a histologic examination. We wish to discuss two methods of obtaining such material.

The first, excision of the scalene fat pad, provides lymph nodes which may disclose the disease process responsible for the pulmonary lesion.

The scalene fat pad is approached through an incision lateral to the posterior border of the sternocleidomastoid muscle, immediately above and parallel to the clavicle. Local anesthesia is used. Such an incision need not be more than five centimeters in length. By combined sharp and blunt dissection with the sternocleidomastoid muscle retracted medially, the scalene fat pad is found lying on the anterior scalene muscle. It can be removed with minimal risk to any important structure and with very little bleeding. If the lymph nodes contained in the fat pad appear grossly normal, then it is advisable to seek paratracheal nodes in the superior mediastinum. These can usually be located by the gently palpating finger if enlarged nodes are present. Exposing such nodes in the superior mediastinum to direct view by utilizing a laryngoscope has been advocated[1]. We have not used this technique, although we have tried using a lighted brain retractor. It seems that if significant nodes are present, they can be easily palpated and removed by teasing the fat pad upward with a minimum of instrumental retraction of the pleura and great vessels. It is important to remember that the parietal pleura is the lateral covering of these paratracheal nodes and considerable caution should be used during their removal. Excessive exploration through this small biopsy incision could rob scalene node biopsy of its greatest assets: simplicity and safety.

*From the Surgical Service, Veterans Administration Hospital, Hines, Illinois.*

The charts of all patients having had scalene node biopsies at the VAH, Hines, were collected and reviewed, up to and including June, 1955. The majority of these biopsies were performed during the last six months of this period. Only those patients suspected of having primary pulmonary disease were included in this study. There were forty-four scalene node biopsies reported as either "normal" or "chronic lymphadenitis". Thirty-three were recorded upon such people.

The remaining eleven were histologically diagnostic. In ten of these, all other diagnostic measures, short of direct attack upon the lesion, had failed to establish a diagnosis. The diseases in which a positive scalene node suggested a diagnosis for the pulmonary lesion were, in one instance each: tuberculosis, Boeck's sarcoid, Hodgkin's disease, reticulum cell sarcoma and on six occasions bronchogenic carcinoma. The other positive scalene node biopsy was in a patient with brochogenic carcinoma, proved on bronchoscopic biopsy. The scalene fat pad was resected in order to help determine the presence or absence of distant metastases. Accepting the presence of distant metastases as evidence of inoperability in bronchogenic carcinoma, the positive scalene node biopsy spared the patient the risk and inconvenience of an exploratory thoracotomy in seven instances. It also prevented an ill-advised thoracotomy in one patient with tuberculosis who had the X-ray appearance and clinical course compatible with tumor and no other previous evidence of this lesion being tuberculous. Whereas the diseased scalene lymph node need not mirror the pulmonary pathology and therefore is not necessarily an indicator of the disease within the lung, the scalene node that is involved with carcinoma can be accepted as a sign of inoperability, even if it provides only presumptive evidence that the primary tumor is in the lung.

There were ten negative scalene node biopsies

in proved bronchogenic carcinomas. Three of these could not be resected at thoracotomy. Scalene node biopsies were negative in three patients who subsequently were found to have active tuberculosis. Most of the negative biopsies not already discussed were in diagnostic problems who remained so. Some have recovered completely and others are chronically ill with symptoms of variable severity.

*Summary of Results of Scalene Node Biopsy*

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|---|---|
| Histologically positive | 25% |
| Made a diagnosis | 23% |
| Prevented unnecessary thorocotomy | 18% |
| Complications (small hematoma) | 4% |

The second type of biopsy maneuver is the most direct and involves obtaining a specimen of lung for microscopic study by one of three approaches:

Thoracotomy with excision biopsy (actually exploratory thoracotomy) with complete removal of the isolated lesion, or resection of the diseased portion of lung, is definitive therapeutically as well as a diagnostic measure.

Needle aspiration biopsy of lung lesions has been recorded on twenty occasions at VAH, Hines; 45 per cent were diagnostic and ten per cent caused complications. In a series of 94 such biopsies, Woolf[2] reported complications in 45 per cent with one mortality. The objections to this method are real: being a blind procedure, the needle may not enter the diseased area, in which case, the tissue obtained will fail to represent the lesion. The deaths reported from needle aspirations within the lung have been thought to be due to cerebral air embolus, although pneumothorax, hemorrhage, and spread of tumor or infection along the needle tract are other obvious objections.

Wedge biopsy of diffuse lung lesions can be performed through a limited thoracotomy incision. There have been eight such procedures carried out at this hospital. In each instance, the specimen was considered diagnostic. There were two cases showing Boeck's sarcoid and one each of the following: epidermoid carcinoma, lipoid pneumonia, chronic granuloma (type not specified), fibrosis, congestion with fibrosis, and foreign body reaction with chronic pneumonitis.

These wedge biopsies were taken through a five to eight cm. incision anteriorly, with resection of a similar piece of rib. During the period that the pleura is open, the lung must be kept fully inflated and intimately opposed to the chest wall to prevent pneumothorax. Intrapulmonary positive pressure is provided by the anesthetist and a portion of the lung herniating out through the incision is obtained for a specimen. The elliptical defect is made air tight by sutures of fine silk and the wound is closed with the lung still fully expanded. This limited thoracotomy has been found less formidable than open thoracotomy, since the operating time is short, little blood is lost, and no postoperative pneumothorax is created if the operation is properly performed. However, the surgeon must be content with the area of lung that presents when the anesthetist inflates the system. Any degree of exploration for a more choice portion of lung from which to obtain a specimen will result in pneumothorax. The occurrence of a pneumothorax is undesirable but not catastrophic, since any residual air can be aspirated by needle post-operatively, or an intercostal catheter may be inserted.

In this series of eight cases, there were two instances of postoperative pneumothorax necessitating water-seal drainage. In both instances the surgeon "explored a little". This complication was not serious and there were no other complications from the procedure. An acceptable diagnosis was made in 100 per cent of these cases. It would seem from this small series that this is a safe and valuable technique. Klassen, Anlyan and Curtis[3], who originally described this operation, reported 50 cases of diffuse pulmonary lesions biopsied by this method, with no pneumothorax nor other serious postoperative complication.

## SUMMARY AND CONCLUSIONS

A diagnostic approach to pulmonary lesions has been presented with a small series of cases illustrating two relatively simple biopsy methods which may be of value and warrants the following conclusions:

1. Scalene node biopsy is a safe operation in experienced hands. It is frequently a valuable diagnostic procedure in cases of pulmonary disease not diagnosed by simpler endeavors. If positive, it can spare a patient with bronchogenic carcinoma the necessity of an exploratory thoracotomy.
2. Indeterminate solitary pulmonary lesions

should be managed by excision biopsy at thoracotomy.

3. The nature of diffuse pulmonary lesions that remain indeterminate despite our best efforts, can usually be clarified by lung biopsy through a limited thoracotomy incision. If exploration for a representative sample of lung is necessary, there is no serious objection to this extension of the maneuver, so long as the resultant pneumothorax is recognized and treated.


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# Parasitic Diarrhea


**John D. Stull, M.D., Olney**


Infestation of the bowel in children with amebas, worms, and other parasites is common. Although there is a great variation in different areas of the country, the return of veterans from overseas, especially from the far East and south European and North African regions, has disseminated these organisms widely throughout the United States. It is estimated that five to 30 per cent of hospital patients have endameba histolytica in their stools, from five to 30 per cent have giardia, while trichomonas and chilomastix, though rarer, occur occasionally. Likewise, the incidence of intestinal worms, especially pinworms and Ascaris, is high. Ten to 30 per cent or more, depending upon the area and living conditions are carriers of these organisms.

I would suspect that our failure to diagnose such parasitic diarrhea is twofold. First, intestinal symptoms caused by any of these infestations do not fall into a clear-cut symptom complex. Diarrhea often is intermittent, lasting only long enough to make the patient think of going to a doctor, but not long or severe enough to get him there. He has a few loose bowel movements every few days to a week or two; occasionally accompanied by blood, pus, and mucus.


*Olney Sanitarium Clinic*



*Presented before the Section on Pediatrics, 114th Annual Meeting Illinois State Medical Society, May 19, 1954.*


Frequently there are periods of constipation, the perennial complaint of mothers, which overshadows the bouts of loose stools and easily leads the doctor astray. Symptoms other than diarrhea often are vague: poor appetite, easy tiring, lack of pep, and irritability. Such complaints repeated over and over again are earmarks of apprehensive parents, and are common in many children with mild psychoneurosis or poor nutritional status or after recurrent infections.

If, as is all too easy to do, we label these complaints psychoneurotic or nutritional or the imaginings of overzealous parents, the diagnosis seldom will be established. In essence, what we need is to consider seriously the possibility of intestinal infestation as a cause of occasional diarrhea and rule out the possibility by adequate investigation.

The second cause is that it is primarily a laboratory diagnosis. Unlike measles, tonsillitis, appendicitis, and a multitude of other diseases where the laboratory may play a secondary role, the diagnosis of intestinal infestation with amebas and some of the worms is primarily made in the laboratory. Laboratories by and large take little interest in odorous specimens, especially if fecal in nature.

Proper examination for these organisms requires a loose bowel movement, preferably diarrheal or after active catharsis; a fresh specimen;

and lots of them. One or two negatives may mean little; occasionally four, five, or more examinations are needed to find the organism. In addition, it requires a laboratory technician who knows what he is looking for and expects to find something; rather than one who gets ready to write "negative" as he leans over the microscope. The use of special techniques to demonstrate the cysts or the eggs, such as concentration by the zinc-sulfate flotation method or cellophane swabs from the perianal region, often are necessary to make a diagnosis.

Of numerous protozoa and worms that may infest the intestinal tract, the most likely to cause symptoms is the E. histolytica. This parasite invades the intestinal wall and produces ulceration of a greater or less degree. The disease is extremely variable in character and the term "amebic dysentery" poorly describes amebiasis as it is known in temperate climates.

Acute attacks of amebiasis with active, bloody, and mucoid diarrhea hardly need comment. I will confine my remarks to what seems to be a commonly observed syndrome in which the diagnosis is less frequently entertained. Symptoms in such children frequently are vague. There usually is some history of bowel disturbance such as infrequent periods of loose stools alternating with constipation. No blood, pus, or mucous is noted and diarrhea may be so mild it is not considered abnormal by the mother. Constipation may be present between the loose bowel movements and cathartics frequently are given. Consequently, the bout of diarrhea may be attributed to success of the mother's home remedies. Occasional abdominal cramping, gas, or nausea also may occur.

Overshadowing these gastrointestinal complaints, however, are the comments about the child's behavior. He becomes irritable and quarrels and cries a great deal. His appetite is erratic; occasionally he eats little and at other times he has a ravenous appetite. He is somewhat lethargic and tires more easily than usual; and complains frequently of vague muscle aches and pains. These manifestations may go on for weeks or months and the child may be taken from doctor to doctor. The child may look chronically ill and somewhat undernourished, his complexion is sallow, and his abdomen is moderately distended. A careful search demonstrates amebas in the stool.

The diagnosis of E. histolytica depends, as I mentioned, on a well staffed, interested laboratory and numerous stool examinations. Stools obtained fresh for demonstration of the motile forms should be supplemented by the zinc-sulfate flotation method for concentration of cysts. These special techniques greatly enhance the chance of making the diagnosis.

The treatment of amebiasis has taken a dramatic turn in the past few years. Emetine, carbarsone, chiniofon, and other drugs may give way to the antibiotics. Aureomycin and bacitracin produce a good percentage of cures, and recent work suggests that terramycin is even more effective. Tobie, comparing aureomycin, terramycin, and bacitracin, found that the ameba and cysts disappear from the stools in 100 per cent of the cases with aureomycin and terramycin at the end of two weeks, but at the end of 2½ months, 40 per cent of those receiving aureomycin again had cysts in their stools, while none of those on terramycin had a recurrence by the end of 6 months. Time will be needed to determine whether such a high cure rate can be consistently maintained. The recommended dose of terramycin is 250 milligrams four times a day for children under 75 pounds and 500 milligrams four times a day if over 75 pounds, for a period of 10 days.

Giardia is another of the common protozoan infestations but there appears to be some question as to the pathogenicity of this organism. It frequently accompanies E. histolytica and the presence of giardia calls for a search for the more pathogenic organism. Giardia is said to produce a celiac type of bowel movement: large, pale, frothy, and loose. Most parasitologists feel that although giardia may be the cause of diarrhea in young children it is rather infrequent.

The present treatment is atabrine, ¾ gr. b.i.d. for 3 to 5 days for small children and up to 1½ gr. three times a day for five days for adults. This is reportedly very effective.

Although theoretically diarrhea may be produced by other protozoas, such as Trichomonas hominis and chilomastix mesnili, which cause heavy infestation in the stool of young children, the evidence is scanty that they are truly pathogenic in an otherwise normal intestinal tract.

Intestinal worms form the second large class of parasites which may produce diarrhea. Characteristically, diarrhea produced by worms is

relatively mild. If it occurs at all in a particular patient, it usually alternates with constipation. Diarrhea normally consists of a few loose bowel movements and occasionally some mucus, but never blood or pus. Diarrhea associated with pinworm infestation often occurs at bedtime and, is difficult to evaluate since loose bowel movements may result from rectal irritation rather than any direct activity in the intestinal tract.

Terramycin, gentian violet, and Antepar® (piperine hexahydrate) are all effective in treatment. Because of cost and ease of administration, Antepar appears at this time to be the most useful. Dosage ranges from ½ teaspoon to 1 teaspoon two times a day, depending on weight, for 7 days, and repeating the course after a 7 day rest period.

Ascaris may cause loose bowel movements, mild abdominal cramping, and abdominal distention. Heavy infestations may produce anemia, poor weight gain, irritability, and easy tiring. Hexylesorcinal given at the rate of 0.1 gm. per year of age up to a maximum of 1 gm. is effective.

Tapeworms and roundworms may cause mild and intermittent diarrhea. In severe infestation, poor weight gain, loss of appetite, and irritability also occur. Oleoresin of male fern is effective. It is given in the dosage of 1 minum per year of age every half hour for three doses, followed by a saline cathartic 2 hours later. Atabrine, a less toxic drug, also is effective. It is given in a dosage of 0.2 to 0.6 of a gm. on an empty stomach, followed by catharsis with sodium sulfate.

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## This is it

The retirement of a physician in the same town or city in which he has practiced for many years poses a special problem. His many faithful and well meaning patients cannot let him retire. He is called at his home to see this one and that one, because no one can do this but "Dr. Jim." This bolsters his ego but it does not help him to retire. There are two solutions to this situation. The first is to move away to another city or section of the country. In so doing, one loses one of his most cherished possessions — his old friends. The second is to take a prolonged vacation such as a world cruise, or take up a temporary abode in another section of the country for six months or a year. When one returns, most of his patients will have found a new physician and forgotten about the old. This is hard on his ego but good for his retirement. This is a lesser problem in a metropolis and a greater one in a small city or town. *Clarence K. Elliott, M.D. How to Retire. Nebraska M.J. July 1955.*

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## Steroid diabetes

Steroid diabetes occurs in less than 1 per cent of patients under therapy with ACTH or cortisone. It is almost always associated with latent diabetes or family susceptibility. Without such a history its production is rare. When it does occur, steroid diabetes usually is mild and reversible and should be no bar to further therapy. *Abraham A. Polachek, M.D. Steriod Diabetes. Maryland M.J. April* 1955.

# The Efficacy of Gamma Globulin in the Control of an Epidemic of Infectious Hepatitis

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SINCE 1952, when Federal regulations made it reportable as a communicable disease and consequently provided accurate information of its widespread incidence, viral hepatitis has received increasing interest by research workers and public health officers. Its generally accepted status as a filth-borne disease gives it major public health significance. While the death rate of this disease has been low, reports emphasize a high attack rate among children, a protracted convalescent period, especially for adults, and a possibility of serious, long-lasting liver damage.

Most reports dealing with the disease in epidemic proportions seem concerned with schools, institutions, or areas wherein a comparable concentration of contacts is noted. Significantly, many such reports note similar problems of sanitation and personal hygiene.

Although no clinically established specific treatment has been reported, some recent reports attest to the value of gamma globulin in abating attack rate or in modifying the severity of the disease.

Such reports hold particular significance and hope for public health workers whose official responsibility lies within schools or institutions housing mentally ill or retarded individuals.

The efforts of public health officers in such institutions are complicated by the mental incapacity of the patients, their general lack of appreciation for sanitation and personal hygiene, their inability or reluctance to verbalize physical complaints or co-operate in treatment, as well as by the present hazards of overcrowding and understaffing.

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This paper reports upon the use and indicated effectiveness of gamma globulin in various stages of an epidemic of viral hepatitis in a state institution housing mentally retarded individuals. Dixon State School, established in 1918 is located in a rural area of North Central Illinois. It is one of two state institutions in Illinois devoted exclusively to the care, treatment, and training of mentally deficient individuals. Its population is comprised of approximately 5,000 patients and 750 staff employees. The patient population ranges in age from 6 weeks to 85 years, with 40% classified in the lower ranges of mental deficiency. Overcrowding and understaffing — the bane of most similar institutions — are encountered at Dixon State School. According to optimum standards, the institution is 47% overcrowded, 30% understaffed.

A total of 104 buildings, 54 of them used for domiciliary purposes, are spread over 1,050 acres of ground. The size of the cottages wherein patients reside varies; the smallest are for school children and accommodate 20 to 25 patients and the largest cottages house up to 160 adults.

Despite these considerations, seemingly conducive to a high incidence of such a disease, the actual incidence of viral hepatitis at Dixon State School — prior to the epidemic of 1954 — was consistent with or lower than the rate of incidence in the local community. In 1952 and 1953, while the neighboring city of Dixon was an epidemic area for viral hepatitis, the Dixon State School registered only sporadic cases. In 1953, 25 cases of viral hepatitis were detected at the school. In the first seven months of 1954, 28 cases were encountered.

The last week of August, 1954, brought evidence that viral hepatitis had invaded the grounds in epidemic proportions. On August 23, a single case was detected in the male wing of a cottage housing 98 boys and 78 girls with an average chronological age of 10½ years and an average I.Q. of 22. Although the boys and girls in this cottage had separate living quarters and supervision, they had a common "day room". Older patients from other cottages regularly assisted staff personnel in caring for these children.

From August 23 to 31, 24 cases were recorded, 21 of them in the same cottage and individual single cases in three other widely separated locations.

Between August 23 and November 27 320 cases were detected. The monthly breakdown is as follows:

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|---|---|
| August 23-31 | 24 cases |
| September | 142 cases |
| October | 149 cases |
| November | 5 cases |

Of the 54 domiciliary units scattered over the grounds, 11 recorded no cases of infectious hepatitis during the period shown above. An additional 24 units recorded from one to five cases each. Four units recorded an aggregate of 109 cases, accounting for approximately 35% of the total epidemic. Of the 320 cases encountered, only 6 involved staff personnel.

Recognition of the threat implicit in the outbreak of viral hepatitis in the cottage, where 16 cases were detected between August 25-27, caused prompt institution of appropriate control measures.

Immediate action was taken to confine the outbreak to this single location by isolation of the cases and quarantining of the wards involved. For this purpose, a complete "break" in the food service, laundry supply, and garbage disposal between the wards involved and the remainder of the institution was established. In this connection, institution carpenters improvised a storage shed outside the contaminated area in which garbage and contaminated laundry were stored, and from which they were hauled away to the laundry or disposal plant.

Each new case brought immediate removal to the isolation hospital for the infected individual and quarantine for the affected residence.

Additionally, each new case brought restriction of all patient activities inside and outside the affected residence, prohibition of all visiting, intensive screening by laboratory tests for suspects, and continuing observation of all patients for abnormal clinical symptoms.

The Isolation Hospital was not equipped or staffed to handle the vast number of cases of infectious hepatitis through all stages of the disease. Therefore, separate isolation quarters were established for patients in the recuperative stages, to assure their convalescence without possible threat of infection to other patients.

One such isolation center was set up for convalescent females and young children, and between October 9 and December 27 a total of 101 patients were processed through this unit.

Another isolation center for males was set up in a farm cottage, some distance removed from the main part of the grounds. Between October 8 and December 14, 90 males were treated at this convalescent center.

During this period 15 "working boys" continued to reside in separate living quarters within this cottage, and none of the group became infected.

Reports of its effective use in connection with similar epidemics influenced the decision to use gamma globulin in an attempt to contain the disease within the initial areas of infection.

There being no clinically established dosage reported, it was decided to give 10.0 cc. by the individual syringe technique to all who might be reasonably suspected of having been exposed to the virus.

Accordingly, on August 29, 145 patients and 86 ward workers and food handlers plus other employees believed to have been exposed to the virus in the initially infected cottage, received an injection of 10.0 cc. of gamma globulin. On September 13 — 16 days after this inoculation —the last of the 58 cases recorded at this location was detected.

Observation in connection with this first group inoculation, generally substantiated by observation of later inoculations, indicated that immunity for the noninfected developed approximately two weeks after inoculation, and that severity

of the attack is lessened for those stricken after inoculation.

Throughout September the infection spread out until 34 cottages were affected and a total of 142 cases reported. On September 5, a similar group inoculation was undertaken at another location where eight cases were detected in a three-day period. All contacts on this cottage, with a population of 72 crippled invalids, including employees as well as patients, received 10.0 cc. of gamma globulin. On the 15th day after group immunization the last case to be recorded at this location was detected.

Similarly, group inoculation was undertaken at a third location on September 17, following an outbreak of seven cases in a four-day period. One case was reported ten days after the immunization and one case as late as 22 days after the immunization.

At the end of September, the belief that gamma globulin had demonstrated its effectiveness, plus the fact that the spread of the infection indicated such all-inclusive prophylaxis, influenced a decision to administer gamma globulin to the entire population of the institution.

In the five-day period, September 30 through October 4, gamma globulin was administered to approximately 5,750 persons, of whom about 750 were employees.

The procedure in the mass immunization called for a single injection of gamma globulin, the dosage being standardized according to age and this dosage varying only when the physician felt the physical condition of an individual warranted it.

The following dosage schedule was used:

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| Up to 1 year | 1.0 cc. | 12 years | 4.0 cc. |
| 1-4 years | 1.5 cc. | 13 " | 4.0 cc. |
| 5 " | 2.0 cc. | 14 " | 4.5 cc. |
| 6 " | 2.0 cc. | 15 " | 5.0 cc. |
| 7 " | 2.0 cc. | 16 " | 5.0 cc. |
| 8 " | 2.5 cc. | 17 " | 5.5 cc. |
| 9 " | 3.0 cc. | 18 " | 6.0 cc. |
| 10 " | 3.0 cc. | 19 " | 6.0 cc. |
| 11 " | 3.5 cc. | 20 " & up | 6.5 cc. |

Experience following the early group inoculations indicated that a period of about 15 days intervened between inoculations and acquisition of immunity. In three of the four early group inoculations, cases were detected on the 15th day following inoculation, and no cases were recorded thereafter.

This motivated the establishment of "the 15-day yardstick" for observation purposes. This period was known as the "protection development period."

Observation following the mass immunization program tended to validate this earlier experience. During the "protection development period" 138 cases were detected, while thereafter only 27 cases, involving 18 wards, were encountered. Of the 18 wards reporting cases after the "protection development period", 15 reported single cases. It was decided to reinoculate the residents of these 18 wards, using the same dosage cited above. Only two cases were reported after this reinoculation, and by the end of November the epidemic was over. December was the only month in the year reporting not a single case of infectious hepatitis.

At the start of the epidemic we gave the considerable thought to proper diagnosis and screening out "suspects" without evident clinical signs. We still had to standardize and simplify our diagnostic methods since we were dealing with an epidemic among some 5,000 mentally retarded persons, living in crowded quarters and cottages without a particular sense of hygiene and sanitation. It appeared to us at that time, and we can confirm it now, that the most important procedure to come to a tentative diagnosis was to obtain a good detailed history of gastrointestinal symptoms and a physical examination with particular emphasis on an examination of the liver for size, consistency and tenderness.

When a patient was suspected, his urine was examined for bilirubinuria. If the test was positive, he was hospitalized or just put to bed and the level of liver damage estimated by bromsulfalein liver function tests. Retention of bromsulfalein of over 5% was considered pathological. This test was preferred to cephalin flocculation although it meant more work for the doctors in injecting the bromsulfalein and drawing blood after 45 minutes. We did not use the icterus index or the total serum bilirubin, although we must admit that the latter test might be of significance in some cases.

We were particularly fond of the bromsulfa-

lein excretion test in the follow-up cases and we used the changeable results as an indicator of improvement. All cases also were examined for urobilogen. Amounts over one Ehrlich unit were considered pathological.

Because of the large number of cases involved, certain follow-up procedures had to be developed for the continued observation of convalescent patients. After strict isolation in our Isolation Hospital and after examination and tests revealed that the patient's general physical condition appeared to be satisfactory, all cases were transferred to two convalescent cottages, one for males and the other for females. Here the patients were kept in bed so long as the liver remained enlarged or tender or the liver function test appeared abnormal.

Urine tests for bilirubin and urobilinogen were done periodically and also bromsulfalein excretion tests. Patients also were given blood counts at regular intervals.

As long as the bromsulfalein test remained abnormal, the patient was kept in bed and was given a high protein, high carbohydrate, low fat diet. After two liver function tests at two week intervals failed to disclose any impairment of functioning or stabilization of the functioning, and the physical examination was negative, the patient was discharged and was returned to the general population.

## CONCLUSIONS

1. It is the opinion of those observing the epidemic of viral hepatitis reported here that gamma globulin played an important role in abating the attack rate as well as in modifying the severity of attack, and that its use as outlined in his report is recommended.
2. Gamma globulin administered during the later part of the incubation period has little, if any, value in warding off the attack, but does appear to reduce its severity and duration.
3. Observation of more than 7,000 inoculations revealed no side effects accompanying gamma globulin injection.

It must be noted that the exact vehicle or mode of transmission of the virus remained obscure despite intensive investigation. Evidence supports the person-to-person route of infection once the virus was introduced into the population, particularly in view of the low standards of sanitary practices among patients.

Without seeking to minimize the role played by gamma globulin, it must also be noted that precautionary methods and measures introduced upon discovery of the infection undoubtedly contributed in some degree to a reduction of the attack rate.

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# Thorazine in the Treatment of Mental Illness in a State Hospital

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THORAZINE®, a trade name for chlorpromazine, is a phenothiazine derivative. It was discovered in France, where it was called Largactil. Some of the original work in that country on Thorazine in mental and emotional disorders was done by Delay and Deneker about three or four years ago.

In a relatively short time the use of this drug has expanded greatly. It is being given in nausea and vomiting, mental and emotional disturbances, alcoholism, intractable pain, and hiccups. As of June 1, 1955 it was estimated that Thorazine has been used in this country in over 3 million patients.

It is a powerful sedative and modifies abnormal human behavior in a novel and useful manner. It has mild antihistaminic properties, moderate inhibitory effects on the parasympathetic system, and marked inhibitory effects on the sympathetic system. Thorazine has the unique quality of inducing sedation without affective disinhibition and without significant intellectual clouding.

Lehman[1] has mentioned that the site of action of this drug is in the brain stem in the region ventral to the thalamus in the subthalamic nucleus, red nucleus, substantia nigra, and hypothalmus as well as in the pontile tegmentum. It is believed that the reticular activating system of the brain is inhibited by chlorpromazine, producing a "pharmacological mesencephalotomy." The best results in psychiatry have been reported in conditions characterized by aggressive, expansive, and euphoric affects and in those chaotic affective disturbances that often are associated with acute psychotic breakdowns of any pathology. The action is less satisfactory in well established depressive states. Confusional states, delusions, and hallucinations seem to respond to the drug only so long as their existence is secondary to a violent affective disturbance.

Lehman and Hanrahan[2] report: "The drug is of unique value in the symptomatic control of almost any kind of severe excitement. This includes catatonic schizophrenia, schizoaffective conditions, epileptic clouded states, agitation occurring in lobotomized patients immediately or several months after surgery, and organic toxic confusional states, as frequently observed in uremic conditions and senile psychoses."

Winkelman[3] reported that Thorazine is "especially remarkable in that it can reduce severe anxiety, diminish phobias and obsessions, reverse or modify a paranoid psychosis, quiet manic or extremely agitated patients, and change the hostile, agitated senile patient into a quiet, easily managed patient."

In August of 1954 I decided to try Thorazine on a group of chronic disturbed psychotics at the Chicago State Hospital. Ward CW19 was selected because it was considered to be the most disturbed, noisy, and combative ward in the hospital. It housed about 170 female patients ranging in age from 20 to 60 years. Most of the patients were in the young and middle-age brackets and about 90 per cent were classified as schizophrenics, 25 per cent of whom were chronic catatonics. There were a few manics, general paretics, mental defectives with psychoses, and one senile patient. In this ward shouting and screaming were typical; fighting was not infrequent. Patients were destructive of clothing, furniture, walls, and plumbing. Attendants often were attacked and injured, their uniforms torn, and glasses and wrist watches broken.

This type of behavior was common in spite of much sedation, hydrotherapy, restraints, and electroshock therapy. There was little occupational and recreational therapy because as the

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*Presented before the Illinois Physicians' Association Section, 115th annual meeting Illinois State Medical Society, Chicago, May 17, 1955.*

nurse in charge now puts it, "No one dared come here before." Doctors hesitated to make rounds on this ward as patients were prone to spit at them, attempt to kick or strike, or grab their clothes. I can personally vouch for this situation, and I would hesitate to make rounds without two attendants to accompany me, one in front and one in back.

When Thorazine was started initially patients were given 50 mg. intramuse. t.i.d. Some of the more disturbed were raised to 100 mg. t.i.d. As soon as patients became quieted down they were placed on equivalent oral doses. The less disturbed patients were brought under control within a relatively short time and maintained on 50 mg. t.i.d. orally. Some of the more chronically disturbed psychotics received parenteral Thorazine for as long as one or two months before they could be shifted to oral medication. Many of the patients are now being maintained on 50 mg. t.i.d.

Within a few weeks after therapy was begun there was a great improvement in the behavior of patients. As present, the ward is quiet. Whereas previously seven to nine attendants were on duty for each shift during the day, now four or five attendants can manage the ward.

Patients on Thorazine as a rule receive no other sedation. Electroshock therapy has been practically stopped in this ward: last month only three treatments were given. The number of injuries on the ward have been reduced to one-third of what they were. Destructiveness to the building, clothing, and furniture has been reduced 75 per cent. Injuries to employees have been cut down at least 90 per cent. The morale of the attendants and nurses working this ward has greatly improved.

Occupational therapy classes have now been instituted. Volunteer welfare workers now come to the ward to visit with patients and some of the improved patients are being taken to movies, church, and the commissary.

Improvement of the patients was primarily in behavior. They became quiet with much less tension, irritability, and restlessness were apparent. They are now co-operative with ward activities. They dress better; at least they keep their clothes on and are more tidy. They eat well and most patients have gained weight. Less belligerence and aggressiveness are noted in these patients now. Most of the patients are more communicative and show appreciation to personnel who converse with them.

In many cases, psychotic thinking did not change much; the patients generally retained their hallucinations and delusions but they talked more freely about them with the doctor. A number of patients when questioned about the drug and how it affected them stated they felt less nervous and excited and more normal.

At present the ward census is 112 patients. Prior to therapy with Thorazine there were 170 on this ward. Because the patients remained chronically disturbed their transfer back to the quieter wards was limited. Now, when severely disturbed patients are admitted to the ward they are quickly brought under control with Thorazine and returned to their original wards. Also, the use of Thorazine in other wards has reduced the need to transfer patients to this hydrotherapy ward.

A number of patients who had been chronic residents on CW19 for months or years improved remarkably and were transferred to better wards. About 20 of this group improved sufficiently to be discharged from the hospital. Others have been placed on industrial and occupational therapy and are more active in recreational activities.

In recent months a study was undertaken with Thorazine treatment to newly admitted, female, acutely ill mental patients who would ordinarily have been placed on shock therapy. A preliminary report at this time indicates that in a number charge of patients from one to several months after admission. Good results were obtained with of cases the response was good, permitting dismanic patients, acutely disturbed schizophrenics, severe psychoneurotics with marked anxiety and depressive features, acute alcoholics, and several agitated cases of psychosis with cerebral arteriosclerosis. Maximum doses in these patients varied from 400 to 800 mg. a day. The average maintenance dose used was 50 mg. t.i.d.

The above results indicate that in many cases of mental illness remissions and improvement can be effected without the use of shock therapies. Psychotic depressed patients did not do as well on Thorazine and usually it was necessary to give electroshock therapy. Chronic schizophrenics without much affect display, generally did not show much change.

Several cases of jaundice occurred, but these were not severe and cleared up fairly quickly. Parkinson states and allergic skin reactions appeared in a few patients but responded to reduction of dosage.

I would like to mention a few cases that showed marked improvement.

*C.H.*—47 year old female, a manic depressive, manic, hospitalized for four years and on CW 19 for three years. She was chronically disturbed, combative, and destructive and had received 132 electroshock treatments. After three months on Thorazine she improved remarkably and was given a conditional discharge from the hospital.

*F.L.*—46 year old negro female, diagnosis: Psychosis with syphilitic Meningoencephalitis. She was chronically disturbed, actively hallucinated, combative, and delusional. She had three courses of penicillin and electroshock treatments without improvement. She received Thorazine treatment for six months and improved remarkably, became quiet and co-operative, showed insight, and was given a conditional discharge.

*M.M.*—54 year old white female, diagnosis: Schizophrenia, chronic undifferentiated type; was disturbed, combative, hallucinated, and did not improve on electroshock therapy. After several months on Thorazine she became quiet and no longer showed antisocial behavior. She still hallucinated but was not disturbed by this. She was given a conditional discharge.

*J.P.*—30 year old single, white female, diagnosis: Psychosis with epilepsy; very disturbed, combative, destructive, hallucinating, and in restraints almost continuously. On Thorazine she rapidly improved within a month and soon after was given a conditional discharge. At present she is not showing psychotic symptoms and is working.

*R.E.*—19 year old single, white female, one child, diagnosis: Acute schizophrenia; was agitated, depressed, hallucinating, and delusional. Treated with Thorazine for 21 days up to 800 mg. per day, she improved rapidly and was discharged from the hospital two months after admission.

*L.I.*—22 year old married, white female, diagnosis: Schizophrenia, chronic undifferentiated type. History of previous admission to Chicago State Hospital in 1952, received electroshock and insulin. She was home for about two years and then again broke down. On present admission she was manneristic, confused and paranoid. On Thorazine for one month, up to 800 mg. per day, she improved rapidly and symptoms of psychosis disappeared. She was given a conditional discharge two months after admission.

*I.S.*—23 year old single female, diagnosis: Schizophrenia reaction, acute undifferentiated. In 1953 she was treated in a private sanitarium with electroshock treatment and had remission for about a year. On present admission she was paranoid, delusional, hallucinating, and combative. On Thorazine for seven weeks with maximum dosage up to 800 mg. Patient improved markedly, psychotic symptoms cleared up, and she was given an absolute discharge three months after admission to the hospital.

Two of the patients treated with Thorazine coincidentally had psoriasis. One, a moderate case of psoriasis, cleared up quickly. The other, a severe chronic case of psoriasis, showed remarkable improvement under treatment with Thorazine.

A possible explanation for the effectiveness of Thorazine in mental and emotional disorders is suggested as follows: Anxiety appears in people when they feel threatened from within or without. Neurotic and psychotic symptoms are considered to be defense mechanisms to reduce or eliminate anxiety. Thorazine, because of its ability to reduce anxiety and disturbing affect responses probably lessens the need for neurotic or psychotic defenses and this permits the patient to reintegrate on more healthy levels. It permits the patient to discuss in psychotherapy his fears, hallucinations, delusions, and conflicts without becoming panicky or overwhelmed by anxiety. Where the affective component in mental illness is marked, the prognosis is better because Thorazine helps control the affect disturbance.

At this point I am convinced that Thorazine is a useful drug in the treatment of acute and chronic disturbed psychotic patients. Its use is a great help in State Hospitals, where we face the serious problems of overcrowding and understaffing. It has boosted morale greatly among the hospital attendants, nurses, and doctors.

Patients are made more accessible for psychotherapy and other rehabilitation procedures, and when these treatment procedures can be extended and intensified I feel the discharge rate from the hospital will correspondingly increase.

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# Allergy in the Specialties

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SPECIALISTS in various fields of medicine, as well as general practitioners, often shy away from interest in allergy for one or two reasons. Many believe in the principle "Let George (the allergist) do it!" Others are of the opinion that allergy is something either unimportant or not applicable to their specialty.

Can George, the allergist, take care of all allergic problems? There are about 10 million allergic people in this country and one thousand allergists. Ten thousand patients is a far greater number than one allergist can take care of. In addition to these allergic patients there are many problems of an allergic nature requiring urgent care, emergency treatment, or some knowledge of the principles of allergy without the encumbrance of having an allergist at your side. Let us examine some of the allergic problems encountered in the various specialties.

## ALLERGY IN THE SPECIALTIES

*Pediatrics.* A pediatrician without interest in or knowledge of allergy is about as handicapped in his specialty as an orthopedist without a background of surgery or a brain surgeon without a knowledge of neurology. In early infancy, colic and eczema present allergic problems to the pediatrician. He is called on to apply allergic concepts, to arrange diets, and to apply topical remedies.

The stuffy nose is another problem. Shall the pediatrician prescribe vasoconstricting nosedrops with their inevitable rebound effect, or shall he take a more fundamental viewpoint and look for allergic factors? Does the child specialist regard the stuffy nose, which is usually allergic, as a minor inconvenience or is he aware that it leads commonly to a high arched palate, orthodontic changes requiring braces, or facial deformity?

Allergic asthma usually begins in childhood, and the attitude of the pediatrician toward it may well determine the course of the entire life of the asthmatic. Does the pediatrician take asthma seriously or does he shrug it off with the careless advice to the parents "to wait to outgrow it?" Many a youngster has become an adult permanently crippled with emphysema and bronchitis as a result of such expectant waiting. "Too young for skin tests" is another dallying attitude which may promote chronicity. And does the pediatrician like to soft pedal his terminology and call it "asthmatic bronchitis?" It helps no one, delays action, and increases the likelihood of complications.

In pediatrics one comes across many other problems of an allergic nature. The interpretation of skin tests is the absolute minimal knowledge necessary to the pediatrician. The possible effects of complicated allergy on growth, the effects of steroid hormones on bony growth, the modern concepts of the allergic nature of certain blood conditions, and the allergenic potentialities of immunizing toxoids and vaccines are among other problems constantly encountered in dealing with children.

*Otorhinolaryngology.* The allergic nose is about the most common type of ailment brought to the rhinologist's office. Many can be helped materially and serious trouble such as sinusitis or polyps may be prevented by sound allergic management. Since a large percentage of patients with allergic rhinitis develop asthma if their allergy is ignored, the rhinologist is in an enviable position to practice good preventive medicine. The rhinologist can become adept at handling these patients along allergic lines or he can refer them to an allergist. He can do more than prescribe pills or delude himself into thinking that vasoconstricting nosedrops or nosepacks give the sufferer adequate relief. In many instances of eustachian tube deafness, the allergic nose is to blame. Some cases of labyrinthitis are on an allergic basis. Irritations of the throat and larynx may be part of the picture of upper respiratory allergy. The good rhinolo-

*Presented before the General Assembly of the 115th Annual Meeting of the Illinois State Medical Society, Chicago, May 19, 1955.*

gist has come to recognize that tonsillectomies do not cure asthmas.

*Ophthalmology.* The ophthalmologist encounters allergic problems frequently. Seasonal and nonseasonal simple allergic conjuctivitis are common. Contact dermatitis of the lids is not uncommon and the eye specialist must realize that the mechanism of this allergy is one of delayed sensitivity, and that the diagnostic procedure is the patch test. Vernal conjunctivitis, with its seasonal trend, the large number of eosinophiles in the exudate, and the relief in certain environments, speak for its allergic character. And yet the nature of its allergy is more or less a mystery and constitutes a challenge to the specialty of ophthalmology.

Lens opacities in the young adult with generalized atopic dermatitis is an allergic problem and the allergic management following recognition of its true nature may prevent full cataract formation. There is no doubt that such conditions as sympathetic ophthalmia, iritis, iridocyclitis, and uveitis can be of allergic origin, either due to infectious allergy or to a process of sensitization to one's own tissues. This is a field deserving considerable co-operative and investigative interest on the part of the ophthalmologist and allergist.

*Surgery.* The surgeon is inclined to believe that his specialty is as far removed from allergy as is the building of skyscrapers from the raising of a flower garden. Yet, consider some of the problems he encounters. Should he operate on the asthmatic? And if he does, what are the dangers of preoperative or postoperative administration of narcotics? When appendectomy, tonsillectomy, or cholecystectomy relieves chronic asthma, was it because disease of that particular organ was responsible for the asthma? Or was it really in line with common experience that any major surgery is likely to relieve allergy temporarily because of the nonspecific effect of traumatization of tissues or of the anesthetic?

The surgeon is confronted with the question of choice of anesthetic in the asthmatic or the possible allergy of the patient to it. Does he know that the skin test is of no value in such cases? He must be especially on guard for penicillin reactions. He must be familiar with allergic abdominal syndromes which simulate the surgical abdomen and with the principles of differential diagnosis. He must not ignore the possibility of severe contact allergy such as occurs from adhesive tapes, local anesthetics, or mercurial antiseptics. He must know the effects of ACTH and the steroid hormones on pain, fever, and the leucocyte count so that their role in confusing the diagnosis might be appreciated. He must know how to protect the patient who has been under therapy with such hormones. And he must be acquainted with the possibilities and sources of allergic reactions from infusions and transfusions.

*Obstetrics and Gynecology.* Whatever applies to general surgery applies equally to obstetrics and gynecology. In addition, a number of special allergic problems arise in this specialty. "What are the chances of my child being allergic?" is a frequent question posed to the obstetrician. What special precautions are needed during pregnancy for the allergic mother? Can she take desensitization treatment for her asthma and hay fever? Does the obstetrician realize that relief of allergy during the latter phase of pregnancy is common and that allergy usually recurs after delivery? Douches and vaginal medications may result in sufficient absorption of medications to be responsible for allergic reactions. The modern obstetrician is fully aware of the Rh problem, but I wonder whether he often stops to think that it is a true allergic phenomenon.

*Neurology and Psychiatry.* The psychiatrist probably has his most intimate contacts with allergy in the form of neuroses and psychoses as a result of severe and long continued allergic diseases. He also encounters situations in which various emotional states and psychic disturbances add to the aggravation of true allergic conditions.

We do not agree with those who claim that most if not all allergic conditions such as asthma, eczema, and atopic dermatitis are primarily psychosomatic phenomena. Unless they are accompanied by allergic manifestations such as asthma, abdominal pain, or eczema we are not convinced that such manifestations as insomnia, jitteriness, lack of ability to concentrate, fatigue, or more well defined neuroses are on an allergic basis.

But it is possible that some neurological disease might be due to allergic causes. Peripheral neuritis following serum reactions is well known.

In some cases of migraine or other cerebral symptoms, allergy may be the etiological factor. Simple headaches may be caused by food allergy. Experimental work in animals indicates that some neurologic diseases, such as multiple sclerosis, might be a type of intrinsic allergic phenomenon. The future may show an increased role of allergy in diseases of the nervous system. Special drugs, such as barbiturates and anticonvulsants, used in this specialty are prone to produce allergic reactions.

*Dermatology.* The dermatologist is literally swamped with allergic problems. While he recognizes their existence he frequently fails to follow through with an allergic approach. The patient with atopic dermatitis, a true allergic disease, often receives only lotions, salves, or X-ray therapy. In some instances the sufferer ends up in the hands of a psychiatrist. Too many dermatologists are satisfied with topical treatment of contact dermatitis as a substitute for careful history taking and patch tests; often these topical applications are responsible for the persistence of the dermatitis.

One of the greatest problems in industrial medicine is occupational, allergic dermatoses of the contact type. Although allergy cannot be traced in a high percentage of the urticarial dermatoses, nevertheless the allergic cases get best results from allergy treatment. The dermatologist also sees other types of allergic phenomena such as ids and fixed drug eruptions.

*Other Fields of Medicine.* The gastroenterologist will encounter allergic causes in some cases of pylorospasm, vomiting, gastric discomfort, colicky abdominal pain, recurring diarrhea, and pruritus ani. The specialist in tuberculosis must constantly deal with the problem of bacterial allergy and immunity, the allergic potentialities of specific drugs, the reciprocal effects of tuberculosis and asthma, and the differential diagnosis of one from the other. The internist must deal with many of the problems mentioned among the other specialties and he is the one called upon to manage the collagen diseases, which are now classed among the manifestations of hypersensitivity.

In the infectious diseases, in nephritis, and in some other visceral diseases the concept of hypersensitivity is assuming increasing importance. The general practitioner encounters not only all the problems met by the other specialists but has a few extra ones. He must take care of allergic situations which are not well defined or have not been classified in any specialty. He is the one who usually bears the brunt or emergency situations and has to make the house calls. He is the one who is most likely to be requested to co-operate with the allergist in carrying out a desensitization program or to supervise the medication. In short, the general practitioner cannot escape the impact of allergy.

## ALLERGY FROM THERAPEUTIC AND DIAGNOSTIC PROCEDURES

Allergic reactions to the increasing array of therapeutic and diagnostic products is the concern of every type of practitioner. Immediate type of reactions, consisting of one or several symptoms of urticaria, abdominal pain, rhinitis, asthma, shock, or unconsciousness may result from a variety of drugs. Among these are aspirin, phenacetin, aminopyrine, phenolphthalein, contrast X-ray media, sulfonamides, hormones, vitamins, liver extract, insulin, vaccines, serum, and antibiotics. The physician must know many facts. For example, he should not be misled by the laboratory report that aspirin gave a negative result on skin tests. Aspirin, like most simple drugs, does not give a positive skin reaction, although the degree of sensitivity to it may be such that the resulting asthma is unusually severe and may even terminate fatally. Skin tests with contrast media also are of no value.

But among this group of atopically reacting drugs some give a positive skin reaction. This is particularly true of serum and penicillin. The physician should know that the patient who shows immediate urticaria or shock after a dose of penicillin would have given a positive scratch or intradermal test before the therapeutic dose was administered. Fatal reactions to penicillin are not rare and usually can be prevented by noting a number of points: previous administration of penicillin, previous reactions from the drug, the presence of other allergy, and a positive skin test. The doctor should know further that the type of penicillin used makes virtually no difference, that small amounts of penicillin are present in many samples of milk on the market (from the treatment of mastitis of cows), and that the polio vaccine contains small amounts of penicillin and streptomycin. Al-

though most of the antibiotic activity of penicillin in the virus vaccine is destroyed by the time it reaches the consumer, there is good reason to believe that the allergenic activity remains. But only the most sensitive individuals would react to such a small amount of penicillin.

A common type of allergic reaction is the serum sickness type, consisting of urticaria, angioneurotic edema, arthralgia, and frequently fever and other findings, occurring a number of days after administration of the drug. This is caused primarily by serum, sulfonamides, and penicillin, the latter having taken the lead. This delayed response to penicillin may last for weeks or months and there is reason to believe that it sometimes leads to visceral disease, particularly periarteritis. This serum sickness type of allergy cannot be forecast by a skin test. The manifestation can occur the first time penicillin is administered and no antihistamine or other therapy will prevent it.

There is a host of other allergic reactions produced by drugs.

### WHAT CAN THE NONALLERGIST DO ABOUT IT?

Every doctor does not need to be an allergist any more than he needs to be a cardiac surgeon. What he needs first is a conviction that allergy is an important phase in his own practice. If his medical school hasn't taught him enough allergy — and it usually hasn't — he should do his best to make up the deficiency. He can attend individual lectures or symposia and meetings of local and national allergy societies. Short intensive postgraduate courses are available, usually in connection with the meetings of the national allergy societies and the American College of Physicians. And there is always the opportunity of reading and studying at home.

It also is the duty of the practitioner to provide improved medical education for the future graduate. Those who formulate medical curricula should listen to the voice of the experienced practitioner who feels that his education in allergy has been inadequate in comparison to its incidence and importance in many fields of medicine. In short, if we are to improve the lot of the future practitioner and future patient we must ask for more adequate undergraduate teaching in this field.

### SUMMARY

No specialty and no field of medicine can be managed without encountering allergic problems. To equip himself to handle such problems intelligently the practitioner requires more discipline in the subject of allergy than his student curriculum afforded him.

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## Treatment of bronchial infections

Bronchial infection such as chronic bronchitis is often associated with chronic emphysema. Paroxysmal coughing and wheezing, with sputum, tends to aggravate the bronchiolar obstruction by exudate and edema of mucous membranes. Repeated upper respiratory infections during the winter months are common in these patients. Bronchiectasis is a rather frequent complication of chronic bronchitis and emphysema. Effective and appropriate antibiotic therapy must be instituted immediately. Organisms from the nose, throat, and sputum should be identified, and sensitivity tests of the bacteria to the various antibiotics should be made. In cases where therapy is prolonged, one must be on the alert for a change in bacterial flora. Reinfections due to these new invaders, as bacteria, molds, and fungi, may be serious. *L. E. Peckenschneider, M. D. The Treatment of Pulmonary Emphysema. J. Kansas M. Soc. Sept. 1955.*

# Pitfalls in the Management of Colles' Fracture

Justin C. McNutt, M.D., Bloomington

COLLES' fracture often is considered too simple for discussion. We have all said to ourselves on occasion "It's only a Colles'. I can fix this one in a hurry and there will be no difficulty". A check X-ray a few days later, however, may reveal that an excellently reduced fracture is no better than it was before starting; or it may be worse or even converted to a reverse Colles' fracture. The patient is experiencing severe pain and has uncontrollable swelling. Too frequently we pass off the patient's symptoms as psychological and because this type fracture occurs most frequently in middle age and older groups and is more common in women, we are prone to blame menopausal and postmenopausal nervous tension and similar factors as the sole cause of discomfort. We thus forget our own inadequacies as the specific cause of disability.

Colles' fracture is a fracture of the distal radius which grossly presents the well known silver fork deformity. X-rays show dorsal displacement of the distal fragment and forewhortening of the overall radial length. Normal anatomical relationships are of prime importance. The normal relationships can be recalled and compared at the time of treatment of the patient by examining the opposite wrist, your own wrist, or the wrist of the nurse. Note in particular that the distal styloid of the radius is about one centimeter longer than the distal styloid of the ulna and there is a concave depression on the volar surface of the radius just beneath the site of palpation of the radial pulse.

In reduction of the fracture, re-establishment of these two important landmarks by palpation usually will terminate in a good reduction and the check X-rays will confirm a satisfactory position. At the same time, the cosmetic result is good and your reputation will not be in jeopardy in the patient's social circles.

Adequate immobilization is imperative in preventing difficulties in the treatment. The word adequate means anatomical adequacy as well as one of time of immobilization. Splints are for emergency, temporary use only and should never be thought of as a method of treatment.

The old basic rule, immobilization of a fracture by including the joint above and below, holds true in Colles' fractures. It is most frequently neglected and undoubtedly accounts for most of the slipping of fragments later on. Failure to include the elbow joint permits the slipping of fragments a few hours or days after intitial treatment. If the elbow is not included, supination and pronation directly by the patient and/or indirectly by muscle action after the normal muscle tone is restored after anesthesia, will rotate the fragments apart with a recurrence of the original deformity or the creation of a reverse Colles' deformity—namely:

1. Shortening of the radius.
2. Dorsal prominence of the ulnar styloid (the bump) which is so visible and undesirable both to physician and patient.
3. Resulting loss of wrist motions, particularly dorsiflexion and ulnar deviation both of which are important to normal hand and finger function.

Swelling, especially when constricted under a cast, causes undue stresses and strains by soft tissue distortion; if allowed to persist fixed deformities result because of fibrosis of the soft tissue structures. This can be averted by careful use of padding, not excessive but enough to pad. Split the cast and padding down to the skin; strands of padding when moist with perspiration act as tourniquets with disastrous results. Plaster bands can be placed around cast to hold until cast is firm. These bands are then easily pulled off or cut.

Even if reduction is excellent, stiffness of hand and fingers usually is due to too much cast over the fingers or too tight application about the metacarpal necks. Allow full finger motion. Note your own hand from a lateral

*Presented before the Section on Surgery, 115th Annual meeting, Illinois State Medical Society, Chicago, May 18, 1955.*

position and see that the palmar crease of flexion of the metacarpo-phalangeal joints is about two centimeters proximal to the end of the metacarpals on the dorsal surface. Trim cast accordingly. In other words, trim back the palmar surface to allow complete flexion at the metacarpo-phalangeal joints.

Thumb position should be that of neutral including its metacarpal. Note on your own hand that the entire thumb ray is normally held relaxed in a position of mid-adduction and mid-apposition, or in a position of unstrained pinching of the thumb and index finger, with the distal corners of their nails approaching each other. Allowing the thumb and its metacarpal to remain entirely out of the cast and in free position as just stated prevents the occurrence of intrinsic muscle contractures.

Position to maintain reduced Colles' fractures:

1. Palmar flexion to overcome dorsal tilt of distal fragment.

2. Ulnar deviation to maintain radial length. If these two factors are not maintained in conjunction with each other, a reverse Colles' may result, or reduction cannot be maintained.

3. Neutral supination-pronation. Easily checked on patient by rotating forearm so that hand is in a nose thumbing position. This is necessary to equalize the action of supinator and pronator muscles.

4. Include elbow in cast, carrying cast high enough on the upper arm to prevent forearm rotation and to prevent weight of forearm from causing the proximal edge of cast from digging into the lower triceps area. Keep elbow at approximately right angles.

5. Split first cast and padding to accommodate swelling.

This position and fixation will hold most Colles' fractures. However, if with one hand you will hold your opposite hand in palmar flexion and ulnar deviation, and you see that finger function is not good and flexion of the fingers causes discomfort, in about two weeks' time the first cast should be removed and the hand gently brought up to a neutral position with very slight ulnar deviation. After this interval of two weeks the fragments are sticky enough that they will not slip.

A snug fitting cast, not necessarily split, is now applied with fingers still free. Neutral position of the hand may be checked by visualizing an imaginary straight line down the shaft of the radius and shaft of the first metacarpal. For this entire procedure do not use any anesthesia because the relaxation will remove the normal sedation with codeine, morphine, or Demeral® splintering effect of the soft tissues. If necessary, usually is sufficient.

Total immobilization should be continued for eight to 10 weeks or until union is solid. After four or five weeks the cast over the elbow may be removed and elbow mobilization instituted. I frequently use the ventral portion of the cast as a part time splint for a few days after cast removal for general comfort of the patient.

Handedness of the patient should be kept in mind in relation to total time of immobilization. Normally a right handed person who injures his right wrist or hand will require longer immobilization because he will put more strain on it sooner than if he had injured his left hand. Left handed persons must be considered conversely. Also a right hand or right wrist injury in the right handed person will by force of natural use be rehabilitated much more easily.

## SUMMARY

In order to overcome the usual pitfalls in the treatment of Colles' fractures it is necessary to:

1. Regain length of radius, maintained by ulnar deviation.

2. Prevent dorsal tilt of radial fragment by palmar flexion of the hand, but do so in combination with ulnar deviation to prevent slipping.

3. Prevent supination and pronation by including elbow in cast with forearm in nose thumbing position.

4. Split first cast and pad to permit unrestricted swelling.

5. Allow free motion of fingers and entire thumb.

6. Change position of hand to neutral in two weeks without anesthesia.

7. Remember handedness in relation to length of immobilization and rehabilitation.

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# Biochemistry of the Heart Muscle

**Harry A. Bliss, M.D., Assistant Professor of Medicine, Moderator.**
**Theodore R. Sherrod, Ph.D., M.D., Associate of Pharmacology.**
**William V. Whitehorn, M.D., Professor of Physiology.**
**Richard J. Winzler, Ph.D., Professor of Biological Chemistry and Head of the Department.**

*Dr. Samter*: In recent months, we have had a series of Seminars on socio-economic and psychological problems which are part and parcel of medicine. We are returning the platform today to the basic scientists who, moderated by a clinician, will discuss current concepts of the biochemical basis for the function of the heart.

*Dr. Bliss*: Thank you Dr. Samter. Some of you may wonder what the relevance of this topic is to clinicians, as clinicians are concerned with the heart as a pump. However, to function as a pump, the heart must have a source of energy; and this function of the heart to convert chemical energy into mechanical energy is the aspect of cardiac physiology with which we are concerned today. Olson and Schwartz have classified the biochemical causes of cardiac failure into two broad categories: (1) failure to produce sufficient energy, and (2) failure to utilize satisfactorily the energy produced. Failure to produce energy may occur for various reasons. For example. in beriberi heart disease a co-enzyme, thiamine, is lacking. In the heart of myxedema, a hormone is absent. Failure of energy production due to lack of substrate may occur in isolated heart preparations, but this has not been demonstrated in the human. Clinically, failure to utilize chemical energy produced by apparently normal oxidative and glycolytic enzyme systems is probably the defect in most individuals with chronic congestive failure. The problem here is the inability to convert chemical into mechanical energy. This type of heart failure is the type that is most successfully treated with digitalis. This is a very sketchy background to our problem. Let us now move on to the meat of our Seminar and have Dr. Winzler discuss the problem of energy production.

*Dr. Winzler*: The general metabolic pattern by which energy is derived from metabolism in animal tissues is fairly well worked out. All of you recall the long and complex series of reactions involved in the metabolism of carbohydrates, fats, and proteins.

In brief review, the accompanying diagram

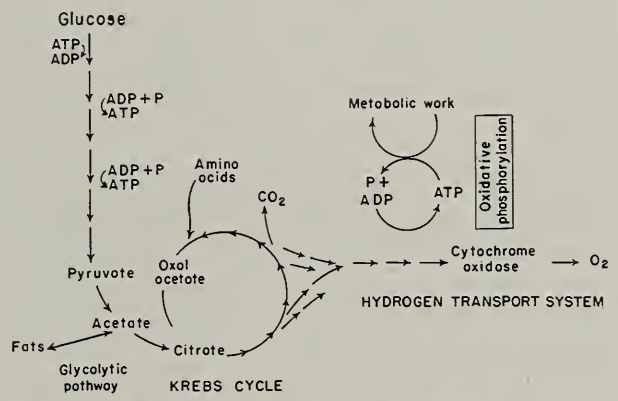



**Figure 1. The role of carbohydrates, fats, and proteins in the production of energy.**

shows that glucose is first metabolized anaerobically to pyruvate in the glycolytic pathway. (Figure 1.) Inorganic phosphate and adenosine

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**UNIVERSITY OF ILLINOIS**

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diphosphate (ADP) are obligatory participants in this sequence of reactions. Pyruvate then enters the Krebs cycle after being decarboxylated to acetate, which then combines with oxaloacetate to produce citrate. Citrate is then sequentially decarboxylated to regenerate oxaloacetate and complete the cycle. From the Krebs cycle, hydrogen atoms and electrons are passed along the hydrogen transport system, ultimately to combine with oxygen and produce water. Fats enter this sequence of reactions by being converted to acetate. Proteins enter into the same sequence by conversion of amino acids to Krebs cycle intermediates. This metabolic pattern is basically a series of reactions resulting in the transfer of substrate hydrogen to molecular oxygen with the liberation of energy. Physiologically, these oxidation reactions are coupled with the production of high-energy phosphate compounds such as adenosine triphosphate (ATP) from ADP and inorganic phosphate. Practically all physiological processes utilizing metabolic energy derive this energy from the splitting of ATP. Most of the ATP generation occurs in the reaction sequence of the hydrogen transport system.

Now how is this energy production and storage utilized during muscle contraction? When a muscle is stimulated to contract, the rate at which glucose is metabolised increases markedly and immediately, and this high rate returns to normal immediately upon stopping the stimulation. How is the rate of glucose breakdown and energy production controlled? What sort of chemical reaction can be stopped and started so readily? Recent evidence points to the intracellular ADP concentration as the controlling factor regulating the rate of metabolism. As is shown in the diagram already given, inorganic phosphate and ADP are obligatory intermediates in the process breakdown. In resting muscle, essentially all of the ADP is converted to ATP and so the overall reaction is slowed due to ADP lack. When muscle contracts, however, ATP is broken down to ADP and the overall reaction sequence speeds up again.

Can we translate this biochemical outline to morphological terms? We know that the unit cell consists of the nucleus, mitochondria, microsomes, and soluble proteins. The glycolytic reactions of the previous diagram are catalyzed

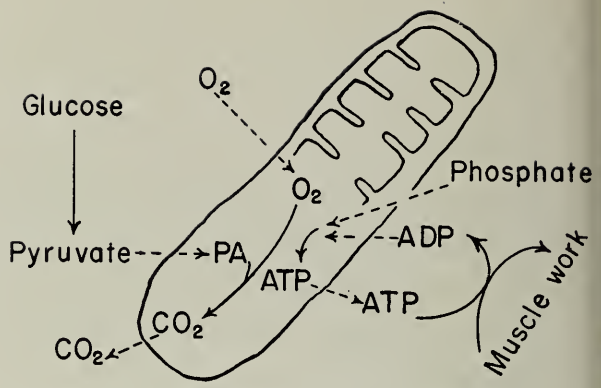



**Figure 2. Chemical reactions within the mitochondria.**

by enzymes occurring primarily in the soluble proteins of the cell. The Krebs cycle reactions, however, are primarily confined to the mitochondria, which are also the locus of the hydrogen transport and phosphorylation reactions. Mitochondria have been shown by electron microscopy to be cytoplasmic bodies with double membranes and many partial septa, largely filling the interior of the mitochondria. (Figure 2.) The enzymes of the Krebs cycle, hydrogen transport system and oxidative phosphorylation system appear to be arranged on these septa. We may speculate that the process of energy storage (as ATP) and utilization (as metabolic work) may perhaps be depicted as shown in the illustration. According to this picture, glucose is metabolized to pyruvate outside the mitochondria. Pyruvate then diffuses along with phosphorus and ADP into the mitochondria, where ATP is produced from energy made available by pyruvate oxidation. ATP may then diffuse out of the mitochondria and become available for muscle or other type of metabolic work. How this chemical energy, stored in the form of ATP can be converted to mechanical energy during muscle contraction is largely an unsolved problem. However, I hope that Dr. Whitehorn will tell us the present status of this work.

*Dr Whitehorn*: I wish to emphasize that the following formulation is a sketchy and speculative presentation of available data. Muscle contraction involves a change in the configuration of a protein complex consisting of actomyosin (a combination of the proteins, actin and myosin), ATP and possibly other factors. The real question is: Why does this change in configuration take place? According to classical

teaching the breakdown of ATP supplies the energy which in some way produces folding of the protein molecules and accordingly shortening of the muscle. Recent work suggests, however, that this concept may require modification. The observations of Szent-Gyorgi, Morales, and others suggest the following scheme: The contractile unit is a zigzag molecule whose length is determined by a balance between molecular forces in its fluid environment which tend to push against it and fold it at its joints, and electrical charges on the molecule itself which repel each other and accordingly tend to keep it from folding. The relationship between these forces determines the configuration of the molecule. It is known that ATP has a high negative charge density. Therefore, the absorption of ATP on the actomyosin molecule results in a neutralization of electrical charges, the balance of forces is disturbed, and contraction takes place. Since, however, actomyosin is an enzyme capable of changing ATP to ADP the latter is formed, its physico-chemical properties are different from those of ATP and the system returns to its previous state. In order for contraction to occur again ADP must be built up to ATP and energy is required. In this scheme ATP is not considered to supply energy directly to the contractile process but is in fact an integral part of the contractile unit.

It is hardly necessary to emphasize the importance of the ionic environment in this process of contraction. Szent-Gyorgi has made interesting observations on the relationship of ions to the strength of contraction of cardiac muscle. He studied the "treppe" effect which, you recall, is a gradual increase in the strength of the first few contractions following a period of rest. He found that the effect was abolished by a low potassium environment, that is, all the contractions were of maximum strength. We know that potassium leaves the muscle during contraction and Szent-Gyorgi postulated that the strength of contraction was related to the rate at which the potassium re-entered. He found that DOC, digitoxin, and an unidentified steroid in serum also abolished the treppe and proposed that they exerted their actions by regulating the movement of potassium across the muscle cell membrane. Later work has indicated that the concentration of other ions such as sodium is also important. It is tempting to speculate that failure of cardiac muscle may be related to changes which upset the ionic environment of the muscle.

Another factor which may result in disturbances of contraction is a change in the structure of the contractile unit. Recent work at the University of Minnesota has involved production of congestive cardiac failure in dogs. Analysis of the hearts of these animals showed that the total amount of actomyosin was reduced, but that the amount of uncombined myosin was increased. These investigators have suggested that since the failing heart dilates, the spatial relationship of the protein molecules is changed and the balance of forces necessary for the proper combination of actin, myosin and ATP is upset.

*Dr. Bliss*: This fascinating account of myocardial metabolism has left us with a little time in which we hope Dr. Sherrod can amplify the role of electrolytes.

*Dr. Sherrod*: Certainly the preceding discussion amply demonstrates the necessity of a normal electrolyte environment for the proper function of the mammalian heart. The high rate of mobility of potassium across the cell membrane may link the electrical phenomena in the cell to the biochemical process which results in muscular contraction. Of all the cations involved potassium seems to play the most essential role. I like to look upon the potassium as acting somewhat in the manner of a "spark plug", while the biochemical processes of potential energy are analogous to the gasoline. Both are essential for the smooth operation of the muscular machine. Just how K serves in the capacity of a "spark plug" and just what its relationships may be to the "biochemical gasoline" in the cell constitutes a very large gap in our information regarding cardiac contraction.

T. R. Harrison was one of the first to suggest, with some experimental justification, that congestive heart failure was associated with a significant potassium deficit in heart muscle.It has been further shown with isotopic dilution techniques that in this condition there is a generalized loss of K from the body. According to Calhoun, heart failure confined to the left side of the heart is associated with a loss of potassium from that side of the heart alone and that following adequate digitalization there is a tendency for the heart to regain its normal complement of K.

There are conflicting reports as regards the effects of the cardiac glycosides on intracellular K. It is generally agreed that toxic doses cause a loss of K and that therapeutic doses facilitate an accumulation of this ion toward the normal. Wollenberger feels that cardiac glycosides may act to increase cell membrane permeability as can be demonstrated with certain dyes.

According to Szent-Gyorgi the contractile elements of muscle consist of an elongated protein conjugate, myosin and its precipitin, polymerized actin. The two proteins are normally attracted by colloidal forces, but are kept apart by an atmosphere of potassium ions. In heart failure, possibly related in some way to altered cell membrane permeability or a disturbance in the movement of potassium from within to the outside of the cell, the union of myosin and actin is inhibited. The cardiac glycosides correct this defect by increasing the mobility of the intracellular K. The temporary dislocation of K from within the cell allows the union of the contractile elements, which then absorb ATP. The resulting actomysin-ATP complex becomes maximally discharged and folded with a loss of energy. Chemical energy is converted into mechanical energy. The enzymatic hydrolysis of ATP follows, with myosin acting as an ATP-ase and with a release of phosphate bond energy to recharge the contractile system. This investigator has shown that extreme dilutions of certain of the cardiac glycosides hasten the spiraling effect of actomysin threads derived from cardiac muscle, but not those from skeletal muscle, and that they also hasten the polymerization of actin.

As Robb states, "After nearly 200 years, almost any day now, the complete mechanism of cardiac glycoside action may become known." There is a great need for more information concerning the molecular events which occur at the cellular level before the mode of action of the cardiac glycosides can be determined with finality.

*Dr. Bliss*: Our time is up. I would like to say in summary that this sort of information presents a background vital for research in the field of cardiac failure and the effect of digitalis on it. Since this syndrome is not easily produced in animals, we shall continue to depend heavily on clinical investigators to further our knowledge.

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## Cytology

I suppose everyone knows something about the smear test and, therefore, I do not need to elaborate on its principles nor do I need to defend it as in the past since its soundness and dependability are now generally recognized. I feel that I should make my position clear by stating that I do not and never did consider cytology a final method of diagnosis and as a substitute for biopsy. The last word still rests with the pathologist. However, cytology is a valuable diagnostic tool and in instances where biopsy is not feasible, its importance is even greater. In cases in which cytologic findings are reported by a qualified laboratory as positive, it would be unwise to set them aside because of lack of pathologic evidence even when repeated biopsies are interpreted as negative. The best results may be expected through the combined use of both the cytologic and pathologic methods by laboratory men with adequate training and experience in both cytology and pathology. *George N. Papanicolaou, M.D. New York Med. Dec. 5, 1955.*

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## Dissent

Doctors of medicine by nature, training, and vocation are individualists. As such, they should be champions of the dissenter, eager to defend the right of another to state his case, ready to weigh the validity of his argument, and willing to accept truth even though it means modifying their original view. This approach, which in no way need lead to compromise of principle, can result only in a healthier profession and greater respect from the public. *Editorial. The Sanctity of Dissent. Texas J. Med. Oct. 1955.*

# EDITORIALS

## The apical systolic murmer

Apical systolic murmurs are encountered frequently in heart examinations. Many are functional and some are organic and it is important to distinguish between the two types. In functional murmurs, there is no structural defect; organic murmurs represent anatomic damage of some kind.

Organic murmurs usually are rough and loud (grade III or more) and are constant and heard over a wider area. They occur early in systole and are accentuated by exercise. For this reason, the examiner ought to ask himself: Is the murmur constant in all body positions and in various respiratory phases? Does it come immediately after the first heart sound or is there a perceptible interval between the two? Is it heard in a circumscribed area at or in the neighborhood of the apex or over a wider area as far as to the left as the axillary line? Is it soft or blowing or rough and harsh, even to the point of producing a thrill? What is the effect of exercise?

Functional murmurs are softer and more circumscribed, tend to come and go, and are influenced by breathing. A history of rheumatic fever suggests an organic basis, more so when there are changes in the size and/or contour of the heart.

Now and then differentiation is impossible to make and in such instances, diagnosis rests with the opinion of those with the greatest reputation, the loudest voice, or the most convincing manner.

## Senate finance committee holds hearings on H.R. 7225

As this is being written, the Senate Finance Committee is holding hearings on H. R. 7225. Medicine had not yet presented its side, but leaders in the American Medical Association and other medical organizations were prepared to appear before the committee.

H. R. 7225 in brief provides for: (1) the pensioning of a permanently disabled person at 50 instead of the present 65-year provision; (2) the lowering of the retirement age of women to 62; (3) payments to disabled children beyond the present age limit of 18; (4) the extension of coverage to virtually all groups excepting physicians; (5) increased contributions by employers, employees and self-employed. By 1975, the cost of social security would be at least double the present figure.

Heretofore, amendments to the Social Security Act have been made only after careful consideration. In Congress, at the last session, H. R. 7225 passed the House in blitz fashion—without hearings and with limitation of consideration on the floor.

Conservative heads in the Senate prevented similar action in the upper body. They managed to have hearings scheduled so as to have all sides present their suggestions and arguments.

One of the main complaints against H. R. 7225 has been that not enough consideration has been given to its effect on the future economy of the nation.

In a press conference after opening of hearings before the Senate Finance Committee,

Secretary Folsom pointed out that this was the first time major social security amendments had been proposed without an intensive study of the program. He expressed satisfaction that the Senate Committee was holding hearings.

The tremendous cost of the proposed program came out with the presentation of the first witness before the Committee. Robert J. Myers, chief actuary of the Social Security Administration analyzed the measure.

Mr. Myers estimated that the proposed amendments would cost $2.2 billion annually 25 years from now. This figure was based on the assumption that the administration of disability benefits would be "strict and tight" and that there would be high employment conditions.

"If either of these assumptions did not materialize, the cost would be considerably higher," he said. "This has been the experience both in foreign systems and in private pension and insurance plans in this country."

From a tax standpoint, the measure calls for an immediate raising of the withholding to 5 per cent, half to be borne by employer and half by the employee. There would be periodical step-ups until a tax of 9 percent would be imposed in 1975.

Under questioning, Mr. Myers said that the cost could eventually go as high as $2.5 billion annually. Experience has been that the expense of governmental projects are usually estimated on the low side.

The committee asked the administration to supply it with the following information:

(1) A broad definition of disability; (2) detailed data on what the impact of the bill would have on the Social Security Trust Fund for next 25 years and (3) a report on what benefits are now available in other federal systems, such as railroad retirement.

Chairman Byrd observed that there might be a "great difficulty" in arriving at a proper definition of disability. That also is the contention of the medical profession. Those who will decide whether permanent disability exists or not will be under terrific political pressure to pass many cases of questionable status. The possible abuses are tremendous.

There are many other inherent dangers in the provision for cash payments for disability. It may retard rehabilitation by removing the incentive to stage a recovery. It may be another step toward federal control of medical service. What is to prevent the age being lowered further, or to broaden the coverage by taking in dependents, or to take in temporary disability, or to make direct cash payments for hospital costs, just to mention a few possibilities?

There are groups other than the medical profession which express the same fears. They, too, feel that the measure's possible effects should be given careful study before a jump is made.

The National Automobile Dealers Association told the Senate Finance Committee that because of the "far-reaching consequences inherent" in the bill, Congress should ask a group of experts to make a thorough and exhaustive study.

The Investors League of New York urged that an independent advisory council conduct a study over the next two years before any important changes are made in the law.

After the Senate Finance Committee completes its hearing—which may be before this article is published—the future course of H. R. 7225 is:

(1) To be held up in Committee for further study or to await a report by a public or private organization or commission regarding its social and economic effects; or,

(2) To be reported out of committee with or without amendments with a recommendation that it be approved by the Senate, and

(3) To be approved or rejected by the Senate in its present or amended form.

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## Doctors oppose social security

What do doctors think of social security? Well the answer is becoming clear. A large number of physicians don't want it on any basis. Some will accept it as a voluntary proposition. But, an overwhelming majority don't want it forced upon them.

In state surveys made in various parts of the country, the number of doctors who believe in compulsory social security for the profession is less than 10 per cent. This surprisingly low figure in view of the hue and cry for forced coverage indicates that the demands have come from a vocal though small minority group.

The largest poll tabulated up to the early part of February was that taken by the Ohio State Medical Association. Ballots were sent to 8,360 members.

The main question was: "Do you favor extension of Old Age and Survivors Benefits coverage of the Federal Social Security program to physicians?" The ballot was accompanied by material prepared by the affirmative and negative sides. The fairness of the poll could not be questioned.

A deadline of November 15, 1955, was set. There were 4,912 ballots returned, or about 60 per cent. Of these 12 could not be tabulated because of irregularity of answers. Of the remaining 4,900, nearly one half—2,441 to be exact—voted "no," indicating that they did not want social security under any circumstances.

Of the 2,459 favoring some form of coverage, 2,070 said they want it on a voluntary basis. Only 370 were in favor of compulsory coverage. Nineteen failed to express a preference.

In Indiana, on the basis of 2,333 replies to 3,613 questionnaries sent out by the Indiana State Medical Association, there is no doubt that social security—voluntary or compulsory—is overwhelmingly unpopular among physicians.

There were 703 doctors who were for some form of social security. Of these, 579 gave their assent to such coverage provided it was voluntary. Only 91 wanted a compulsory program. The others did not state their preference.

The physicians also were sounded out on the question of legislation, such as the Jenkins-Keogh Bill, which would permit deducting from current income the cost of purchasing a retirement plan. The answers were: Yes, 1,617; no, 256.

The Rhode Island Medical Society and Providence Medical Association polled 800 members. Usable returns were received from 450. Opposition to any form of social security totaled 152. Those favoring a voluntary system numbered 264. Only 34 voted for a compulsory program.

In Florida, the Florida Medical Association obtained 1,581 usable returns from 2,330 questionnaires. There were 1,020 doctors who wanted no form of social security; 279 had a desire for social security coverage and 282 said "yes" provided the limit of $75 a month maximum earnings to receive benefits were "substantially raised or eliminated."

The Arkansas Medical Society sent out about 1,200 questionnaires and to the end of January had 836 usable replies. There were 785 votes against a compulsory program. Of these, 411 doctors were acceptable to a voluntary coverage but 374 wanted no part of social security. The proponents of a compulsory plan numbered 51.

Responses were received from 717 doctors to a questionnaire sent out by the Essex County Medical Society, Newark. Four questions were submitted, but many physicians answered only some of the questions. The tabulation:

(1) In favor of compulsory social security for physicians: yes, 148; no, 440.

(2) In favor of extension to cover physicians on voluntary basis: yes, 460; no, 196.

(3) In favor of a voluntary tax exempt pension plan: yes, 461; no, 126.

(4) Against any extension of social security laws to cover physicians: yes, 148; no, 371.

All age groups were emphatically on the negative side as to the questions 1 and 4 and positive as to questions 2 and 3.

The Medical Association of the State of Alabama submitted four propositions:

(1) Coverage of physicians by social security; should be left out, 267; for optional coverage, 421; for compulsory program, 37.

(2) On cash disability benefits at 50 years: good plan, 119; unimportant to medical profession, 105; harmful and should be opposed, 477.

(3) On changing amount of benefits: should be increased, 104; should be left at present levels, 463; should be reduced, 100.

(4) On changing the age of eligibility: should be lowered, 122; should remain at present level, 505; should be raised, 62.

There were 242 returns from 450 questionnaires sent out by the Vermont State Medical Society. The results were: For compulsory program 37; for voluntary coverage 183; no social security, 22.

The American Academy of General Practice queried 900 physicians for opinions on social security coverage. There were 91 per cent against a compulsory program; 83 per cent favored a voluntary plan.

This represents a pretty good cross section of the physicians of this country. Other surveys probably will confirm these early findings that the medical profession certainly wants to be excluded from any compulsory social security coverage.

Despite all of the propaganda put out by would-be socializers of medicine, only one doctor

out of 10 considers social security as a protection for the future.

The American Medical Association opposed the inclusion of physicians in any Social Security program on a compulsory basis. It has stated that it will not oppose an amendment permitting voluntary participation.

While it appears a certainty that the American Medical Association has been expressing the views of a majority of doctors on that subject, the House of Delegates at the recent meeting in Boston decided there should be no question about that. The House adopted a resolution recommending that state medical societies poll their memberships and to transmit the results to the Association's Board of Trustees as soon as possible.

In accordance with that request, the Council of the Illinois State Medical Society at its meeting in January voted to conduct such a poll in Illinois. That is in process.

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## You got to take it

We hope the Illinois Medical Journal does not receive the same treatment as the British Medical Journal. An English physician wrote an article which appeared in the Queen's Medical Magazine, in which he says "The British Medical Journal has an assured circulation among the whole profession, the majority of whom are members of the Association. The recipient may not want it, he may not know how to open the wrapper, but he has got to take it."

The author then reported the following incident: "A friend of mine in general practice was disturbed at his breakfast table by the ringing of the front doorbell. He went to answer it himself, having frequently complained of the inability of other members of the household to take messages correctly. He was wearing carpet slippers, clutched a table napkin in one hand, and had his mouth full of bacon. He was feeling irritable. At the door stood the postman, a patient with an ailing wife (who suffered from low backache and singing in the ears) and a large family. My friend said, 'Now, what is it?'

"The postman produced a drab, dun-colored cylinder from his bag. He said, "Ere's yer mag.' My friend said, 'Take the damn thing away. I don't want it. Burn it.' The postman said, 'Can't destroy private mile without you sign a form.' My friend said, 'Why didn't you shove it in the letterbox instead of disturbing me at my breakfast?' The postman said, 'It's too fick.'

My friend then took the publication and threw it with the utmost violence into some flowering shrubs by the surgery entrance. Later he had the aperture of the letterbox enlarged. This allowed the rain to drift in during inclement weather and made the letters soggy. The postman transferred himself, his wife, and eight children to another doctor who was not a member of the Association. A very sad case."

The Illinois Medical Journal could be in a similar position: It has an assured circulation among the physicians of Illinois and they get it whether they like it or not. But the editors hope the majority of readers enjoy the contents and profit by the scientific material presented. It is your journal and we welcome suggestions, comments, and correspondence.

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## Blue Cross passes 50,000,000

Enrollment in the 86 approved Blue Cross plans in the United States, Canada and Puerto Rico was 50,179,264 persons as of September 30, 1955.

Nearly one out of every three persons in the United States is a Blue Cross member. In Canada, five plans have enrolled 26 per cent of the combined population of eight provinces.

"More and more people are seeking protection against unexpected hospital and medical costs through prepayment," said Samuel Oseroff of Pittsburgh, chairman of the Blue Cross Commission. "At the same time, the areas prepayment must reach and the types of service it must cover are enlarging."

"The really remarkable aspect of this membership of 50 million is that Blue Cross has grown so big in a short time. We believe Blue Cross has been successful as a prepayment program because it offers a simple but sound method for budgeting against unexpected hospital costs."

More than 6,000 hospitals today participate in the Blue Cross program. Hospitals during 1955 received more than $885 million for the care of 8,000,000 Blue Cross members, representing an all-time high in Blue Cross payments to hospitals.

## A. M. A. meeting to be held in Chicago

The 1956 Annual Meeting of the American Medical Association will be held in Chicago, June 11-15. The center of activities and the exhibits will be presented at the Navy Pier on the near north side of Chicago. Headquarters for the House of Delegates will be the Palmer House.

Some 350 technical exhibits and more than 300 scientific exhibits will be on display throughout the session. Among the scientific features already scheduled are; fracture and fresh pathology exhibits; physical examinations for physicians; exhibit-symposiums on traffic accidents and arthritis and rheumatism, and special exhibits on cardiovascular diseases and pulmonary function tests.

The Illinois State Medical Society and the Chicago Medical Society will act as hosts. More information will be published in succeeding issues of the Illinois Medical Journal.

We would urge physicians everywhere to plan now to attend this 1956 annual meeting and to make their reservations early. A physician attendance of from 12,000 to 15,000 should be attained for the Chicago meeting, held near the center of the nation.

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## Edward H. Ochsner 1868-1956

Edward H. Ochsner of Chicago died at the Augustana Hospital, Chicago, January 22. Doctor Ochsner was born in Wisconsin, and graduated from Rush Medical College in 1894. Following his internship at the Cook County Hospital, he began to practice in Chicago. He spent considerable time in Europe, taking special work in surgery, and at one time worked under Germany's socialized medicine plan to get first hand information relative to the type of service that could be given under the panel system. He was always bitterly opposed to all types of government medical care and wrote many articles opposing socialized medicine, which were published in medical publications.

He was president of the Illinois State Medical Society in 1924, and was a delegate to the A.M.A. from this society on a number of occasions. Doctor Ochsner was opposed to what he termed "ultra-specialization" in medicine. He defined an ultra-specialist as a doctor "who knows more and more about less and less until he knows everything about nothing".

For many years Doctor Ochsner was a member of the surgical staff at the Augustana, where his brother, A. J. Ochsner, was chief of staff in surgery until his death. He was a charter member of the American College of Surgeons, and a member of many other medical and surgical organizations. Doctor Ochsner was the author of a number of books on socialized medicine, social security and other subjects on medical care.

He retired from active practice about 20 years ago, and spent considerable time at his farm in Wisconsin. He was a member of the Fifty Year Club of the Illinois State Medical Society, and a member of the Fifty Year Club Committee. He was a regular attendant at the annual luncheon meeting of the Fifty Year Club during the annual sessions, and was always present at the Annual Dinner with the other past presidents of this Society.

Following the death of Mrs. Ochsner a few years ago, his failing health caused him to give up all work, and he resided at the Belmont Hotel on Sheridan Road until his terminal illness. He is survived by two sons, Herbert and Raymond, and two daughters, Mrs. Marion Pease and Mrs. Alice Kieweg.

Nearly all of the members of the Illinois State Medical Society knew and admired Doctor Ochsner for his many achievements and his ardent desire to see medical care continue to be given in this country under the system of private enterprise. He will be greatly missed by thousands of friends in this state, as well as elsewhere throughout the country. His friends and former associates join with the officers and Council of the Illinois State Medical Society in extending sympathy to his family.

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## Chicago doctor proposed blood bank 80 years ago

The blood bank may be considered a modern development of medicine but a proposal for the establishment of such a project was made 80 years ago by a Chicago physician, Dr. Joseph W. Freer. In 1875, Dr. Freer reported on the transfusion of blood and among other things suggested a storage of blood.

This interesting bit of medical information is related by Dr. Kellogg Speed of Chicago in a

chapter on "General Surgery" Volume II, "History of Medical Practice in Illinois." (*)

The account in part follows:

"Dr. Freer said that for the previous nine years he had performed experiments at Rush Medical College in which he had bled dogs all out from the carotid artery (syncope), defribinated the blood, and injected it into the jugular vein. He had thus resuscitated all but one animal, and one dog thus treated was alive for one year.

"There was reference to the technic of transfusion by direct arterial connection or by a double nozzled syringe. Also the use of lamb's blood and the fatalities following it were discussed.

"A case from the Cook County Hospital was cited of hemorrhage and shock; the patient was given by transfusion 8 ounces of blood from an uncle (a physician) and recovered. Details were given of dog experiments to ascertain the length of time blood retained its nutrient and vivifying qualities, and Dr. Freer stated that he even used some blood kept in the refrigerator 48 hours with successful revival of a bled-out dog.

"He advanced the idea of saving blood for future use, and the use of animal as well as human blood. *This may well represent the birth of the Blood Bank in Illinois.*"

Volume II of "History of Medical Practice in Illinois" is replete with hundreds of interesting items which physicians may use to good advantage in papers and talks. The book should be in the library of every doctor.

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## Congratulations, New York!

The Illinois State Medical Society extends its congratulations and greetings to the Medical Society of the County of New York, which will celebrate its 150th anniversary in April.

The Medical Society of the County of New York with its membership of 7,000 not only is the largest local society but it carries on the traditions of medicine to the honor of the entire profession. The fact that it has achieved a high status in meeting the critical public relations problems confronting it is a measure of its current leadership and its progressive and forward thinking.

(*) *Arranged and edited by Dr. David J. Davis, Chicago. Published by Illinois State Medical Society, 1955. From pages 175-176.*

## Illinois physicians in service

Jay C. Alameda, Peoria, Peoria
Richard H. Bick, Knox, Knox
Henry P. Bourke, Chicago, C.M.S.
James E. Bowman, Jr., Chicago, C.M.S.
Robert E. Boyd, Jr., Oak Park, C.M.S.
Charles E. Branch, Piper City, Ford
Edmond M. Brophy, Champaign
Raul M. Casas, Chicago, C.M.S.
Gilbert B. Causey, Normal, McLean
Kyle W. Chapman, C.M.S.
George L. Chesley, Bloomington, McLean
Elizeo M. Colli, Carroll
J. Richard Cooper, Adams
George E. Cruft, Winnebago
Rufus S. Courtney, C.M.S.
Clayton R. Curtis, Grayville, White
David O. Dale, Minier, Tazewell
Wm. T. Davin, Glen Ellyn, DuPage
Harold R. Diamond, C.M.S.
John P. Doenge, Olney, Richland
Ralph Elson, Highland Park, Lake
Mahmud T. Faruki, C.M.S.
Joseph E. Fields, Joliet, Will Grundy
Hugh A. Flack, Chicago, C.M.S.
Neil F. Flaherty, Chicago, C.M.S.
Donald B. Frankel, Fairfield, Wayne
William I. Freud, C.M.S.
Melvin L. Goldeye, Lake
Jose L. Gonzales, C.M.S.
Harold Goodman, Chicago, C.M.S.
Irving M. Greenberg, Chicago, C.M.S.
Sidney Greenberger, Chicago, C.M.S.
Jack L. Greider, Decatur, Macon
William D. Griffin, Peoria
Alvin Groupe, Arenzville, Cass
Carl W. Hagler, Adams
Junji Hasegawa, C.M.S.
Carl J. Hauptmann, Harrisburg, Saline
A. Lee Haydary, Green Valley, Tazewell
Loren O. Hotz, Skokie, C.M.S.
Keith R. Irish, Park Ridge, C.M.S.
Arthur T. Janecke, Chicago, C.M.S.
Max E. Johnson, Newman, Douglas
Marshall Kanter, Chicago, C.M.S.
Harold M. Kaplan, Chicago, C.M.S.
Bernard M. Kaye, C.M.S.
Roy W. Kenney, Jr., St. Clair
Gene J. Kinder, C.M.S.
Ben A. Kinsman, Perry
Melvin F. Kupke, DuPage
Eli W. Lane, C.M.S.
John M. Langstaff, Livingston
Gilbert Lanoff, C.M.S.
Clarence A. Lathrop, Chicago, C.M.S.
Homer L. Lawder, Champaign, Champaign
Robert C. Lescher, River Forest, C.M.S.
Frank L. Lesko, Danville, Vermilion
Fred H. Litwin, Chicago, C.M.S.
Allan L. Lorincz, C.M.S.
Harry L. Luzzie, Chicago, C.M.S.

William I. Mandel, Champaign
Harold M. Manfredi, C.M.S.
Roland A. Manfredi, Chicago, C.M.S.
Aaron A. Mannis, C.M.S.
Raul M. Martinez, Oak Lawn, C.M.S.
Ramon L. Maseda, C.M.S.
Sam Matlin, Chicago, C.M.S.
William F. McDonald, Chicago, C.M.S.
Patrick B. McVary, Springfield, Sangamon
John J. Mera, Rockford, Winnebago
Robert D. Morgan, Marion, Williamson
I. Odiaga, Maywood, C.M.S.
Placido R. Oses, Peoria
Wayne R. Otto, Ogle
Jerry R. Owings, Lincoln, Logan
Ralph Pacini, Elmwood Park, C.M.S.
Leon P. Palermiti, Will Grundy
Luke R. Pascale, Chicago, C.M.S.
Bernard T. Peele, Chicago, C.M.S.
Cecil G. Piper, Mt. Carroll, Carroll
Milton Plafker, Chicago, C.M.S.
Adolph J. Rabinovitz, Chicago, C.M.S.
Herbert S. Radley, C.M.S.
H. A. Raubitschek, Chicago, C.M.S.
Bernard Z. Reizner, Winnebago
William W. Robinson, Morrison, Whiteside
Daniel Roth, Williamson
Jerome Rowitch, Chicago, C.M.S.
Clyde A. Rulison, Roberts, Ford
James H. Saft, Chicago, C.M.S.
Marvin Salant, Chicago, C.M.S.
Ricardo E. Saldivar, Chicago, C.M.S.
Edwin C. Salter, McHenry
Wallace L. Salzman, Libertyville, Lake
Stanley C. Samowitz, C.M.S.
Vincent C. Sarley, Chicago, C.M.S.
Louis F. Scaramella, C.M.S.
Melvin L. Schwartz, Chicago, C.M.S.
Ralph E. Seward, Peoria, Peoria
Nathan Scechter, Rock Island, Rock Island
Maurice J. Sheerman, Jr., C.M.S.
Richard G. Shifrin, Chicago, C.M.S.
Norman R. Shippey, East St. Louis, St. Clair
Paul Siever, C.M.S.
Raymond R. Simpson, Alton, Madison
Ben I. Smaller, C.M.S.
Joseph S. Solovy, Chicago, C.M.S.
George A. Stanford, Peoria
Emil P. Stipak, Chicago, C.M.S.
Nathan Subotnik, C.M.S.
George C. Sutton, Evanston, C.M.S.
Thomas S. Szasz, C.M.S.
Peter S. Teresi, Chicago, C.M.S.
Pierce W. Theobald, Evanston, C.M.S.
William S. Thompson, Elmhurst, DuPage
Jay E. Turner, Chicago, C.M.S.
Albert H. Unger, Chicago, C.M.S.
Sheldon A. Walker, C.M.S.
Martin M. Werner, Chicago, C.M.S.
Robert B. White, Aurora, Kane
Benham R. Wrigley, Peoria, Peoria
David S. Yatzkan, McHenry
Arthur J. Zweibel, C.M.S.

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## Big business

In the National Institutes of Health there are seven Institutes: the National Cancer Institute, the Mental Health Institute, the National Heart Institute, the Dental Health Institute, the Micro-Biological Institute, the Institute for Neurological Diseases and Blindness, and the Institute for Arthritis and Metabolic Diseases. The total annual appropriation for the National Institutes of Health and Clinical Center amounts to about $71,000,000. The new clinical research center could conceivably house 1,500 beds but more than half of the hospital is taken up with laboratories. Its 500 beds are simply the center of its vast research and study facilities. This hospital was built at a cost of about $60,000,000. The total cost of the entire plant, including all other buildings of NIH, is put at about $76,000,000. *Herbert P. Ramsey, M.D. The Washington Medical Scene. Med. Ann. District of Columbia, Nov. 1955.*

# MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

# Trends in the Practice of Medicine

Roland R. Cross, Jr., M.D., Chicago

DURING the usual Winter's program of the Medical Society, there is an evening devoted to "Trends" in various phases of medicine. It is well that we should so be brought up to date. But, while we are being refreshed in Cardiology, Surgery, Dermatology and etc., we should, also, be led from time to time in the discussion of new trends in the practice of medicine. Nothing is static. Progress, or maybe we should say change (for not all change is progress), is continual. In one sense, medicine is a marketable entity, and there is a buyer. The purchaser, as any psychologist of the laws of marketing will tell you, is influenced by the commodity.

In 1954, President McCormick, in his Presidential Address before the A.M.A. in San Francisco, spoke at length on the idea of a fixed fee schedule. Here was a prominent, ethical, seriously-minded physician speaking on a subject to which he had given much thought. He stated, "The time has passed when the medical profession can predicate a fee on a patient's salary, or whether he is in a private room or a ward, or lives 'on the hill' or in a moderate residential area." From the visible and audible reaction, it would seem that the idea has been studiously avoided, and yet it fails to die. Not too long ago "Time" reported how a local County Medical Society, in meeting the competition of the Kaiser Permanente Foundation, brought forth a variation of a fixed fee schedule. This Society — The Alameda Contra-Costa County Medical Association — brought out a median fee index. They distributed a leaflet to the public informing them that this was the fee the public was to expect unless the *doctor told the patient differently prior to initiating the procedure.* I am sure the public, if it thinks consciously, would feel that the competition of the two systems of "packaging the product" is beneficial.

"Time" of December 19, 1955 has an article in its Medical Section entitled "Yardstick for Fees." This news report tells of the yardstick worked out by the Los Angeles County Medical Association. It is to be applied to patients making less than $6,000 per year. Some suggestions are: a broken wrist $75.00; appendectomy $175.00; tonsillectomy $75.00 and gallstone operation $250.00. The Los Angeles County Medical Association vetoed this; but, official or not, it exerts an influence as a yardstick.

The thoracic surgeons, as a group, recently adopted a point system for fixing charges, and who can say that surgical insurance fees have not, to some extent, served as a yardstick. Many a physician has had a patient come with his insurance literature, showing the fees allowed for certain procedures, and wanting to know if they would be done for that amount.

And, of course, this brings up another trend, namely, the use to which Union Health and

Welfare funds are being used. These funds are a new development that are included in what is known as fringe benefits. A person who pays his own medical costs can deduct the same from his income tax, if they are sufficiently high. But, when it is paid by the Union, it does not ever appear as income — the result is complete deduction.

A recent A.M.A. Washington Newsletter carries this news item:— "At least 11,290,000 workers under collective bargaining contracts were covered by some type of health and insurance or pension plans in 1954. The most popular coverage, next to life insurance, was hospitalization, which was provided to 88 per cent of all workers employed under union contracts. Next, was surgical coverage with 83 per cent, accident and sickness with 73 per cent, accidental death and dismemberment 54 per cent, and medical benefits 47 percent." The Bureau of Labor Statistics' report showed that new benefits (diagnostic and laboratory services, emergency accident care, and the like) were being introduced into the agreements regularly. *Management* rather than labor generally assumes the cost of new benefits as they are added, and some contracts even have management assuming full cost of protection for dependents.

These funds are being used in different ways. Different unions are competing with each other to give their members a better system. One large plant in St. Louis gives their members relatively complete medical care, including dental care. Chicago now has three new clinics (two diagnostic centers and one both diagnostic and treatment). Philadelphia has recently witnessed the dedication of a beautiful new building where medical care is given to union members. Everyone is familiar with the John L. Lewis' United Mine Workers' Health and Welfare Fund which is building several hospitals for members. The mine workers, in the period of 1946-1955, spent $246,253,374.29 for hospital and medical care for its members, and, during this same time, the total revenue of the mine workers' Welfare and Retirement Fund was $882,423,780.68. This amount of money represents "big business."

A good example of one of the new union clinics is as follows:— It has a fulltime medical director, a medical administrative officer and 22 part-time physicians, all of whom are either Board men or Board-eligible. The nucleus of this group is the internists. As each new patient enters the clinic, he becomes the patient of one of the internists, who becomes his personal physician, and, in effect, his medical manager. The patient may be seen in consultation and for treatment by the specialties, but the patient always returns to the same internist. Complete laboratory and x-ray services are included. Arrangements have been made for the filling of prescriptions by reputable drug firms at a discount to the patient. The one thing the patient has to pay for is medicine. He takes his own prescription to the drugstore and pays for it himself as he receives it. Thus, these people receive a high caliber medical care as a "fringe benefit", paid by the employer.

One should remember that these methods of "packaging the product" are yet in their beginning. They will probably grow and enlarge. And, in one viewpoint, one might say that insofar as unions establishing clinics for their members are concerned, they are in effect fixing a standard fee schedule.

Another trend, not necessarily new but still having a new aspect, is concerning the fee charged by a physician. The American College of Surgeons has long been loud and vocal in its denunciation of any division of fees. In this respect, the AMA Code of Ethics has been definite against the division of fees, but its action in practice has been mild. Other groups, such as the American College of Physicians, have ignored the problem, and, by implication consider it to be mainly of concern to the surgeons. And the public feels that the whole matter is a factional matter and fight within the family of medicine. The recent rise of a stronger voice for the general practitioners has finally resulted in the Truman Report. It is interesting that the Truman Report was given its widest distribution by the Journal of the American Academy of General Practitioners, G-P, and by Medical Economics, and, yet, it is an honest and sincere report by physicians. The members of the reporting committee were Dr. Stanley Truman, Dr. J. S. De Tar, Dr. Felix Butte, Dr. James Q. Graves, Dr. Ernest Irons, Dr. Leland McKittrick, and Dr. Walter Palmer. Dr. Dwight H. Murray, as Chairman of the AMA Board of Trustees, called this report "the most constructive and exhaustive work relating to the problem of fee-splitting ever written."

Some of the main points of this Report are:— "There is general agreement among doctors that there are greater financial rewards for surgery than for medicine. There is higher public status for the doctor who does surgery. There is more intense competition among doctors for surgical work. The economic aspects of this competition are not now really free and open, but is, at least partially, regulated by arbitrary restriction. All of these factors combine to create a climate which encourages unethical practices. The relief of these pressures should make it easier for more doctors to maintain higher ethics in their practices."

The Report recommended the creation of a subcommittee of the Medical Practices Committee to work on a relative value scale for the whole of the practice of medicine and surgery (using the scale already produced by the thoracic surgeons as a starting point).

The Committee stated that it could see little hope for curing fee-splitting by superimposing more oaths, rules, restrictions, regulations and inspections, for there remains a long human history of broken oaths and regulations. "Many doctors who are pleased with their practices as they are may prefer not to see changes; however, we have ascertained to our complete satisfaction that the financial inequities and the attempts to departmentalize medicine within rigid, artificial boundaries are basic causes of unethical practice."

All of this discussion serves merely to call attention to trends and influences. The practice of medicine is changing under the influences of these and many other trends. The package used to dispense the product will doubtless be greatly different in the years to come.

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## Negligence in England

The large number of legal actions brought against physicians and surgeons still is causing concern. A new feature of the annual report of the Ministry of Health is the inclusion of tables to show the frequency of claims and proceedings against hospitals and their medical staffs. These demonstrate that compensation payments of all kinds, largely in negligence cases, rose from 23,636 pounds in 1950 to 159,047 pounds in 1953. In his report, the president of the Medical Defense Union has said that the number of claims for alleged medical negligence was 80 per cent higher in 1953 than in 1947. The report of the Ministry of Health states that there is no evidence of deterioration in the standard of medical practice and attributes the increased litigation to a number of factors. Perhaps the most important of these is the decision in several recent court cases that, under the law, the hospital is responsible for the negligence of its servants. In the days of voluntary hospitals, there was a great loyalty to the local hospital and its staff and this acted as a forceful deterrent to persons who might otherwise have considered legal action. Now that the local hospital is no longer "our hospital" but just a part of the National Health Service, proceedings are taken aganist it without any personal feelings whatever. Another factor that has doubtless increased the number of actions and has been responsible for a number of the frivolous ones is the provision of free legal aid. *John Lister, M.D. By the London Post. New England J. Med. Nov. 24, 1955.*

# THE P. R. PAGE



**Survey shows what public expects**

The public expects from doctors: sympathy, patience and understanding, rather than guaranteed cures and "wonder drugs." Criticism is based on matters of time and economics, not of personality or ability.

This is the finding of an independent survey conducted under the sponsorship of the American Medical Association. Three thousand people in all walks of life were interviewed. The concensus was:

(1) People almost universally like and respect their personal or family physicians; they think more highly of their family doctor than of doctors in general.

(2) Attitudes about doctors are far more favorable than unfavorable; majorities deny most of the frequently voiced complaints about doctors when speaking of their own; many people accept certain charges against doctors as a group which they reject for their own physicians.

(3) Doctors in general are liked most for their friendly personality, sympathy and competence.

(4) Chief complaints are: fees, hurrying of patients, coldness, lack of frankness.

Chief recommendations of the public were: Come when called, lower fees, take more personal interest, be more friendly, be frank on illness and fees, take more time with patients, keep appointments better, inform the public.

From these answers, the survey conductors reached the conclusion: "Since people apparently feel more favorably inclined toward their own doctors than toward most doctors, it is not the public relations of the individual physician which requires increased attention, but the public relations of the medical profession as a whole.

"People's attitudes toward their own doctors are based upon their own personal experiences, while their attitudes toward doctors in general must necessarily be based upon secondary information and hearsay."

One surprising finding was that only 48 per cent of the public interviewed said they had knowledge of the American Medical Association and its purposes and that only one fifth of these could recall any thing specific. The chief recollection concerned general publicity, drug researches, professional standards, conventions and opposition to government medicine. Good to favorable impressions were held by four out of five of these laymen.

The public generally feels that the purpose of the American Medical Association is to promote better medical standards and to keep doctors informed. One out of 25 laymen dislikes the Association's stand on government medicine.

Five hundred doctors also were surveyed. They were closely agreed with the public on the appraisal of most physicians as to intelligence, capability and willingness to accept medical advances. On some other points doctors were more critical of their colleagues than was the public. On questions of income and fees, physicians had

more favorable opinions of themselves than people have of their own doctors.

From these findings, the survey concluded: "It seems evident that the individual doctor needs to form a better opinion of his colleagues and to convey that opinion to his patients. If he himself helps create derogatory impressions of other doctors, he thwarts the public relations efforts of his profession."

A poll of the professional attitude toward the American Medical Association showed that three out of four doctors generally were satisfied with the policies. A third felt that more could be done to improve the relationship with doctors. The main suggestion was "get closer to doctors, poll their ideas."

"One conclusion drawn from the study is that state and country societies as well as the American Medical Association must do a more comprehensive job of familiarizing individual members with Association activities, aims and policies," the report said. "Many of the criticisms given by doctors reflect lack of information or actual misunderstanding of basic concepts and associational procedures."

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**Activities of county societies**

Activities of the nation's county medical societies cover a wide range, according to a 1954-1955 survey made by the American Medical Association. A feature of the study was the revelation of a growing awareness of the need for participation in community affairs.

Answers to questionnaires were received from 1,225 societies, or nearly 64 percent. Of these, 764 reported that they had public relations committees. Other committees or activities of PR importance included:

Ethics, 526; grievance, 704; emergency call service, 710; public health, 550; school health, 379; mental health, 225; liaison with voluntary health organizations, 334; speakers bureaus, 240; health forums, 168; state and county fair exhibits, 131; health days, 95; radio programs, 207; television programs, 116; indigent care programs, 614; use of average or usual fee schedule, 654; cancer control, 873; tuberculosis control, 895; blood bank plans, 777; venereal disease control, 445; health examinations, 368; multiple screening programs, 123; safety programs, 139; diabetes detection, 737; rheumatic fever control, 403.

**Hospital costs medical PR problem**

Fast-rising hospital costs have been the biggest factor in the upswing in medical care expenses. From 1946 to 1954, the consumer's price index rose 37.6 per cent; hospital costs in the same period increased 132 per cent.

The spiraling is to continue, according to Ray E. Brown, president of the American Hospital Association. Mr. Brown, in a press interview, said we can look for a 5 per cent increase annually for several years.

He explained that hospitals must meet general rising wage rates but, unlike industry, the institutions cannot offset this by higher productivity through the use of machinery. In 1946, hospitals had 1.48 employees per patient; in 1954 it was 1.98.

Hospital stay averages have been reduced — from 9.1 days in 1946 to 7.8 days in 1954 — but patients cannot look for much further drop in that direction.

Mr. Brown said perhaps new patterns of hospital service may be developed so as to permit more ambulatory care rather than personal attention, thus curbing the rising trend.

Meanwhile, the medical profession is confronted with a PR problem — to explain to the public that hospital costs, and not doctors' fees, are mainly responsible for the increases in medical care expenses.

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**New bills with PR implications**

A number of bills with public relations implications for the medical profession have been introduced in the present session of Congress. These include:

S. 3076: To authorize the Surgeon General of Public Health Service to make special studies to determine the extent of illness, disability and related conditions. The information to be sought will include the number, age, sex, extent of disability among chronic cases, types of disease of handicapping conditions, length of disability, amount and rehabilitation and medical services being received, and economic and other impacts of illness and disability. The WPA made a similar survey 20 years ago, interviewing about 737,000 families.

H.R. 8863: To appropriate $16 million for a four-year program of aid to states to care for the aging. Of this, $2 million would help finance a survey of facilities and needs, and the remaind-

er would be apportioned to states on a formula, more money going to low-income states. The bill also would establish a Bureau of Older Persons in HEW.

H.R. 8583: To liberalize VA regulations on presumption of service connection by extending the period from the present one year to three years for arthritis, and from two to three years for multiple sclerosis and psychoses.

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**A.M.A. offers new TV film**

The American Medical Association has released a half-hour film, "Medicine, U.S.A.—The Living Proof," for TV presentation over local stations under state and county medical society sponsorship. It deals with cancer survival and gives case histories of eight patients. H. V. Kaltenborn is the interviewer. What the medical profession is doing for cancer victims is related.

"If you have a working arrangement with a local television station for public service programs, may I suggest you get in touch with the program director and reserve a spot time for 'Medicine, U.S.A.'" said Dr. George F. Lull, secretary and general manager of the A.M.A.

"Some societies with regular half hour programs are pre-empting their own shows in order to get this vital news-education feature on the air as soon as possible. If your society has never sponsored a public service TV show, this might be a good chance to break the ice."

Booking requests should be sent to the A.M.A.'s Bureau of Health Education.

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**New A.M.A. health exhibits**

The American Medical Association's Bureau of Exhibits has scheduled two new health exhibits, both featuring lifesize, three-dimensional models of parts of the body.

One deals with the eye, and will be ready April 1. A special feature will enable viewers to check themselves on nearsightedness, farsightedness and color blindness.

The second exhibit, on the ear, will show the mechanism of hearing. It also will feature motion sickness, the mechanics of hearing aids and quackery. The exhibit will be available May 1.

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## Psychoallergic

It is told that a psychiatrist entered an allergist's office one day, leading a young lady by the hand. The psychiatrist was anxious to prove to the allergist that urticaria could occur on an emotional basis alone and was offering this young woman as evidence. Her complaint was that every time she had a falling out with her boy friend, she promptly developed generalized urticaria. Since she had had a spat with the boy friend the day before, she now was suffering from one of her attacks of "hives." The allergist examined the patient and noticed that each urticarial wheal had a punctate center and resembled an insect bite. When the girl was carefully questioned she admitted rather reluctantly that her bed was infested with bed-bugs. The psychiatrist could not understand the relevancy of his fact to the outbreaks of urticaria following arguments with the boy friend until the young lady very oblingly solved the entire problem. She admitted that the only time she slept in her own bed was following a fight with her fiance. *Samuel S. Burden, M.D. The Role of the Psyche in Allergic Disease. Ann. Int. Med. Dec. 1955.*

# CORRESPONDENCE

## New ruling for filling out birth certificate forms

What is good news for form-harassed physicians came in the announcement by Dr. Roland R. Cross, director of the Illinois Department of Public Health, that in filling out certificates of live births and stillbirths, answers to questions beyond No. 25 are optional.

The first 25 items on the certificate forms are required by law and must be answered.

The notice which Dr. Cross sent January 31 to all local registrars read in part:

". . . items 26 and following of the Supplemental Medical Report on the reverse side of the Live Birth and Stillbirth Certificates are to be considered optional items, and any certificate which is completely and satisfactorily filled out in all respects except for the omission of items 26 and following is acceptable for filing. It is understood, of course, that reporting on all items preceding item 26 on the certificates is mandatory."

Physicians cannot object to supplying essential and pertinent data for birth certificates. They have cooperated fully with state and national health authorities in the completion of vital statistics reports.

Most states have a standard form, which has been adapted to local needs. According to Dr. Halbert L. Dunn, chief of the National Office of Vital Statistics, U. S. Public Health Service, the basic information collected has not changed much in the half century that birth and death certificates have been in use. (*)The forms have been changed to keep the certificates up-to-date rather than to inroduce any real innovations.

Now that Dr. Cross has clarified the Illinois picture by his ruling, physicians will be able to submit more speedily and accurately the answers to the 25 questions required by law.

As for answering the optional questions, No. 26 and beyond, that is up to the individual physician.

(*) J.A.M.A., 159:1184-1186 (Nov. 19) 1955.

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## Colchester Lion's Club honors Dr. Bruce A. Harrison

On January 26, Colchester, Ill., paid tribute to one of its most distinguished citizens, Dr. Bruce A. Harrison. Dr. Harrison has served the community for more than 45 years, having located there in 1910 soon after finishing his internship. The dinner part was arranged by the Lion's Club, of which Dr. Harrison is a charter member.

Believing that he and Mrs. Harrison were to attend a ladies' night meeting of the Club, Dr. Harrison was surprised to find some 240 of his friends awaiting his arrival. In a town boasting of only 1,600 inhabitants, it was a difficult matter to prevent the doctor from finding out what was being prepared to honor him, but obviously it was done.

The Illinois State Medical Society sent its President-Elect, Dr. F. Lee Stone of Chicago; the Chairman of the Council; Dr. Joseph T. O'Neill, of Ottawa; the Councilor for the 4th district, Dr. Charles P. Blair, and the Secretary, Dr. Harold M. Camp from Monmouth. Dr. F. Garm Norbury, President of the Society, had

been invited, but was out of the state. He sent his greetings and best wishes to Dr. Harrison and expressed his regrets that he was unable to attend.

Dr. Camp acted as M. C. for the program, introducing Dr. Stone who told of the improvements in maternal and infant care during the past 45 years. He referred to the fine work fo the Society's Maternal Welfare Committee which has functioned for nearly 20 years, and the gradually lowering each year, of maternal and infant death rates.

Dr. O'Neill told of the development of the specialty of pediatrics, most of which has occurred since the turn of the century. He compared the many infantile ailments of the past with those of today, and the gradual decrease in both infantily mortality and morbidity.

Dr. Blair told about the major improvements in medical and surgical care. It was his opinion that perhaps the most outstanding development has been in cardiac surgery. Following these a presentation was made to Dr. Harrison by his friends. A corsage was presented to Mrs. Harrison.

Dr. Harrison is a native of nearby Fulton county where his father practiced medicine for more than 30 years in a small town. His father had two physician brothers, one practicing in Quincy and the other in Texas. He graduated from the College of Physicians and Surgeons of the University of Illinois in 1909.

There were many physicians present from nearby Macomb, and from a number of other places, who came to aid in honoring an associate of long standing. The Lion's Club and other friends of Dr. Harrison stated that they desired to pay respects to one who had served their health interests faithfully over more than 45 years while he was able to be present and appreciate their interest in him and his work. It was their belief that this arrangement was much better than having a memorial service to his memory after he is gone from their midst.

Dr. Harrison's son, Bruce Jr., his daughter, Mrs. Don Erskine of Cleveland, and the doctor's grandson, Don Erskine, Jr., were present.

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## Clinics for crippled children scheduled for April

Twenty-three clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois Division of Services for Crippled Children. There will be 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with nursing and medical social services. There will be 5 special clinics for children with cardiac conditions and one for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected from private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services. More than 10,000 visits were made by physically handicapped children during 1955.

Clinics listed for April are as follows:

April 3 Carmi—Carmi Township Hospital

April 3 Quincy—Blessing Hospital

April 4 Hinsdale—Hinsdale Sanitarium

April 5 Flora—Clay County Hospital

April 10 East St. Louis—St. Mary's Hospital

April 10 Peoria—Children's Hospital

April 12 Cairo—Public Health Building

April 12 Elmhurst Cardiac—Memorial Hospital of DuPage County

April 12 Springfield—St. John's Hospital

April 12 Watseka—American Legion Hall

April 13 Chicago Heights Cardiac—St. James Hospital

April 17 Danville—Lake View Hospital

April 19 Rockford—St. Anthony's Hospital

April 18 Alton Rheumatic Fever—Alton Memorial Hospital

April 18 Chicago Heights—St. James Hospital

April 19 Rockford—St. Anthony's Hospital

April 24 Effingham Rheumatic Fever—St. Anthony's Hospital

April 24 Peoria—Children's Hospital

April 25 Elgin—Sherman Hospital

April 25 Springfield Cerebral Palsy—Memorial Hospital

April 26 Bloomington General (A. M.)—St. Joseph's Hospital, Cerebral Palsy (P. M.)—St. Joseph's Hospital

April 26 Mt. Vernon—Masonic Temple

April 27 Chicago Heights Cardiac—St. James Hospital

## International Academy of Proctology annual conference

The Eighth Annual Convention of the International Academy of Proctology will be held in the Drake Hotel, Chicago, April 23-26. A well-rounded program covering major developments in proctology will be presented in papers, panel, symposium and motion pictures.

Subject matter will include ulcerative colitis, carcinoma of the rectum and colon, hemorrhoids, ano-rectal strictures, pilonidal cysts, surgical complications of anorectal surgery, polyps, amebiasis, diverticulitis, fluids and electrolytes in gastrointestinal surgery, anesthesia and many other related subjects, according to Dr. Caesar Portes of Chicago, chairman of the program committee.

A full day will be devoted to a motion picture seminar. Panel discussion of all phases of anorectal diseases will take place. An afternoon will be devoted to it. Participants will answer questions from the floor and a general discussion will follow.

Chicago surgeons who will participate in the program are: Drs. Leon Aries, Walter C. Bornemeier, Roland R. Cross, Harry A. Gussin, Earle I. Greene, Joseph B. Kirsner, Edward Kowalski, Edward J. Krol, Manuel E. Lichtenstein, Joseph D. Majarakis, Karl A. Meyer, Caesar Portes, George J. Rukstinat, Max S. Sadove, Sidney J. Shafer, William H. Shlaes, George Shropshear, Manuel G. Spiesman, Arkell M. Vaughn, Harry F. Weisberg and Joseph R. Wolff.

Dr. Louis S. Wegryn of Elizabeth, N. J., will give his presidential message at the opening session. Dr. Manuel G. Spiesman of Chicago will be installed as the president for 1956. Dr. F. Lee Stone of Chicago, president-elect of the Illinois State Medical Society, will give an address of welcome.

Further details may be had by writing Dr. Alfred J. Cantor, secretary, International Academy of Proctology, 147-41 Sanford Avenue, Flushing 55, N. Y.

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## St. Louis City Hospital alumni meeting

The annual St. Louis City Hospital Alumni Association meeting will be held April 9, 1956 at the LeChoteau Resturant, St. Louis, Missouri. The meeting will be held in conjunction with the Missouri State Medical Association meeting. All former interns, residents and staff members are invited to attend. Fore reservations write Drennan Bailey, M. D., Secretary 634 North Grand, St. Louis 3, Missouri.

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## Promotions for AF medical and dental

The Office of The Surgeon General, USAF, announced that all physicians and dentists now serving on active duty in the grade of First Lieutenant will be promoted to the temporary grade of Captain effective 1 February 1956 if they have acquired (12) months of professional experience subsequent to graduation from medical or dental school and are otherwise qualified. All medical and dental officers now serving on active duty in the grade of First Lieutenant will be promoted to the temporary grade of Captain when they attain the above eligibility requirements.

When physicians and dentists holding permanent reserve commissions as First Lieutenants in the Reserve of the Air Force are ordered to active duty after 1 February 1956 they will be promoted to the temporary grade of Captain on the day they enter active duty if they have acquired twelve (12) months professional experience after graduation from medical or dental school and are otherwise qualified.

This is another action proposed by the Armed Forces Task Force Group appointed last June by the Secretary of Defense to explore the critical problems of attracting and retaining career medical and dental officers.

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## Eleventh annual Schering award competition opens

Students are invited to participate by selecting one of three suggested subjects and submitting papers to the Schering Award Committee, Bloomfield, N.J. Both a $500 first prize and $250 second prize are offered for each of the three subjects. Decisions are made by a group of judges who are authorities in their respective fields. In addition, every participant in the contest receives a professionally useful gift.

The three subjects for 1956, announced by C. J. Szmal, M.D., chairman of the Schering Award Committee, are:

1. The Clinical Use of Adrenocortical Steroids in Collagen Diseases
2. Metabolic Aspects of the Aging Process
3. New Applications of Antihistamines in Medicine and Surgery

Literature and entry forms are being distributed in the medical schools. Students who are interested in participating, either individually or in teams, should submit their entry forms before July 1, 1956 and manuscripts must be postmarked not later than Sept. 30, 1956.

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## International College of Surgeons regional meeting

On April 26-28, 1956, the International College of Surgeons will hold a regional meeting of its American section in Madison, Wisconsin, with headquarters at the Loraine Hotel. This will be a Mid-West meeting with all surgeons presiding in this area invited to attend. Leading surgeons from throughout the United States will appear on the prorgam.

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## American goiter association meeting

The 1956 meeting of the American Goiter Association will be held in the Drake Hotel, Chicago, Illinois, May 3, 4 and 5, 1956.

The program for the three day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.

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## Summer camp for diabetic children

A summer camp for diabetic children will be opened for the eighth season under the auspices of the Chicago Diabetes Association, Inc., from July 15th, 1956, to August 5th, 1956, at Holiday Home, Lake Geneva, Wisconsin.

In addition to the complete camp personnel, the Chicago Diabetes Association furnishes a staff of resident physicians and dietitians, trained in the care of diabetic children.

Boys and girls, ages eight through fourteen years are eligible. For further information regarding fees, interested persons should be directed to write or phone the office of the Chicago Diabetes Association. Fees will be set on a sliding scale to meet individual circumstances.

Physicians are urged to notify parents of diabetic children and to enter the names of children who would like to attend the camp. Applications may be obtained from, and inquiries should be addressed to:

The Chicago Diabetes Association
5 South Wabash Avenue
Chicago 3, Illinois
ANdover 3-1861

Limited capacity requires prompt application.

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## Cervical tension

The cervical tension syndrome arises from the discrepancies of the cervical vertebrae. The resultant symptoms include pain, soreness, or stiffness of the neck referred to the occipital, parietal, or frontal areas. Mild to severe unilateral or bilateral headaches frequently result. Pain may radiate into the shoulders, arms, and even as far as the hands or fingers or there may be associated pain in the chest, middorsal, or scapular areas. In patients past 40 years of age, a frozen shoulder or the shoulder-hand syndrome may complicate the picture. Vertigo is not an infrequent symptom. Some patients describe symptoms of blackout sensations or crazy feelings in the head. *William K. Ishmael, M.D. The Problem of Painful Spine. J. Oklahoma M.A. Nov. 1955.*

# AT THE EDITOR'S DESK



Bioflavonoids are being ballyhooed for the treatment of 101 different ailments. Aeeording to a reeent press release, these produets are more than 20 years old and 800 medical papers have been written on their value in rheumatie fever, tonsillitis, influenza, nosebleed, ehieken pox, complications of diabetes, abnormal menstrual flow, upper respiratory infections, tooth extraetions, and coronary thrombosis. To top it off, the release also says, "Most doctors who have studied bioflavonoids feel they are of supplemental value in all diseases."

The bioflavonoids are abundant in plants, fruits, and vegetables and eontain earbon, hydrogen, and oxygen atoms. The most potent of the 200 flavonoids are found in the yellow parts of eitrus fruits like oranges and lemons. Physicians should be familiar with a produet that is reeeiving so mueh publieity among the laity. Manufacturers admit they are trying to break into the eold remedy market and get their share of the $200 million spent annually by the publie on antihistaminie produets.

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The Wm. S. Merrell Co. has sent out several releases on Frenquel, their new antihallueinatory, anticonfusion drug. Dr. Nina Toll was quoted as saying, "the new drug helps make offiee psyehotherapy with sehizophrenie patients more effective and shortens the eourse of therapy." After taking Frenquel, one of Dr. Toll's patients said, "It is easier to think things out. I understand more quiekly what people say to me." Another stated, "I feel I don't want to be alone any more. I won't run away from the battle any more. They (the pills) make my mind feel better."

In a later Merrell release, Dr. Harold E. Himwich, Galesburg State Research Hospital, was quoted as follows: "A remarkable feature of the drug is the absenee of clinical side effeets. Other drugs, useful in treating this type patient, must be used with caution to avoid unwanted aetions potentially dangerous to the patient's physieal health." Dr. Himwich used large doses of Frenquel in treating these patients but said, "The absenee of toxie actions is an exeeptional advantage. The fear of eomplications is removed."

Rutaminal-RQ is Sehenley's new reserpine-quercetin combination. A news release for publie eonsumption states it is "a supportive adjunct in the treatment of a variety of eardiovaseular disorders, among whieh are coronary artery disease and angina peetoris, hypertensive vaseular disease, and arteriosclerosis."

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The press relations department of Lakeside Laboratories, Inc. announeed the debut of Tridal. The eompound is a eombination of Dactil and Piptal and is aimed at bringing immediate and prolonged relief of pain and spasm in gastrointestinal traet disorders.

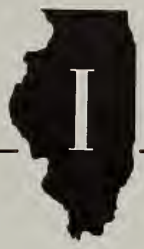
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Merrell also reported that "Meratran is an effective aid in weight redueing because it helped patients adjust as painlessly as possible to a low calorie diet." (The release did not say how or what the product eontains.)

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"Tyzine nasal solution rated superior in Air Foree study," reads the title of a publie relations release of Charles Pfizer & Co., Ine. This nasal decongestant "was evaluated as excellent by 48 of the 60 airmen treated for nasal congestion aeeompanying upper respiratory infeetions."

# NEWS of the STATE



## ADAMS

**Society News.**—Dr. Orville M. Graves, Jr. and Mrs. Frank Brenner served as co-chairmen of the Annual Social meeting of the Adams County Medical Society at the Elks Club in Quincy, January 20.

**New Officers.**—Dr. Alfred Ash was chosen president-elect of the Adams County Medical Society at its meeting, December 12, 1955. Dr. Newton DuPuy was installed as president. Other officers are: first vice-president, Dr. George Borden; second vice-president, Dr. Guy L. Tourney; secretary, Dr. Robert C. Murphy; treasurer, Dr. Harold Swanberg; accounting officer, Dr. Walter M. Libmann; editor, Dr. Hilliard M. Shair; assistant editor, Dr. William U. McReynolds; medical legal advisor, Dr. Ralph McReynolds; historian, Dr. H. O. Collins; counselor (three years), Dr. Carl F. H. Pfeiffer, and censor (three years), Dr. Clifford A. Hendricks.

**New Physicians in Quincy.**—Dr. Leonard D. Grayson, a dermatologist, has joined the Physicians and Surgeons Clinic and will be associated with Dr. Hilliard M. Shair. Dr. Walter Ulbrich, a radiologist and formerly of Dayton, Ohio, has become associated with Dr. Harold Swanberg.

**Quarterly Meeting.**—The regular quarterly meeting of the Adams County Medical Society was held at the Lincoln Douglas Hotel, Monday evening, Feb. 13. It was preceded by a dinner in honor of the speaker, Dr. Franklin E. Walton of St. Louis, Associate Prof. of Clinical Surgery, Washington University. Dr. Walton gave an illustrated talk on the surgical treatment of cancer of the stomach. He related the great value of the X-ray in making a diagnosis and emphasized the importance of early diagnosis and radical surgical treatment.

At the business session, Dr. George W. Shannon and Dr. Givi Gabliani, both from Quincy, were elected to active membership in the society. Representatives of Parke, Davis & Co., of Detroit, showed a sound, colored movie, emphasizing medical research and the training necessary for careers in medicine and some of the allied professions. The next meeting of the society will be held on Monday, April 12.

**Personal.**—Dr. Richard E. Meyer, Quincy, was recently certified by the American Board of Ophthalmology.

## COOK

**The Physician Looks at Legal Problems.**—The Chicago Medical School opened a series of lectures, January 10, on a series titled "The Physician Looks at Legal Problems." Dr. Arthur A. Levisohn, also an L.L.D., professor of Legal Medicine at the Chicago Medical School, opened the first lecture with a talk on "The Doctor and the Last Will and Testament." Other speakers in the series were: Clifford Shaw, A.B., head, Sociology Service, Illinois Institute for Juvenile Research, administrative director, Chicago Area Project, January 17, on "Social Aspects of Delinquency"; Joseph H. Hinshaw, L.L.D., attorney at law, January 24, on "The Medical Man on the Witness Stand"; Austin W. Brues, director, division of biological and medical research, Argonne National Laboratory, January 31, on "Occupational Hazards of Radiation"; Sgt. Daniel T. Dragel, Scientific Crime Detection Laboratory, Chicago Police Department, February 7, on "Chemical Tests for Intoxication"; Rabbi Louis Binstock, D.D., D.H.L., Temple Sholom, February 14, on "Medicine and Law as Found in the Bible" and Charles A. Bellows, J. D., Attorney at law, February 21, on "Insanity and the Law."

**Branch Meeting.**—A clinical pathological conference featured the meeting of the North Shore Branch of the Chicago Medical Society, January 3. Dr. Edwin F. Hirsch, director of pathology at St. Luke's Hospital, acted as moderator. Other participants were: Drs. Norman Roberg, associate professor of medicine at the University of Illinois Col-

lege of Medicine, Ralph Dolkart, associate professor of medicine at Northwestern University Medical School and L. W. Peterson, Illinois Masonic Hospital.

**Society News.**—At a meeting of the Chicago Neurological Society, December 20, speakers were: Drs. W. A. Gustafson, on "Choroidal Artery Ligation for Parkinsonism" (presentation of a patient); C. Whittaker and N. Wetzel, on "Intraspinal Dural Cyst"; A. H. Norton and Benjamin Boshes, on Graphic Studies in Tone and Tremor" (preliminary observations in the Parkinsonian state).—The Chicago Pediatric Society was addressed, December 20, by Drs. Isabel Lai-Fong Szeto and Heyworth N. Sanford, on "Alkaline Resistant (Fetal) Hemoglobin in Infancy and Childhood"; Mila Pierce, on "Treatment of Childhood Leukemia"; Robert Miller, Howard Traisman and Herbert Philipsborn, on "Hemodynamics of Puppies During Simulated Exchange Transfusions".—At a meeting of the Society of Medical History of Chicago at the Institute of Medicine, December 14, Dr. Lester S. King spoke on "Similia Similibus", and Dr. Israel Davidsohn, on Medical Caricatures—A Mirror of Medical History.—Dr. Caesar Portes acted as moderator in a round table discussion on "Recent Advances in the Treatment of Ano-Rectal Diseases" during a meeting, December 7, of the Illinois Chapter of the International Academy of Proctology.—The Chicago Heart Association was addressed recently by Drs. Philip Lee and Howard A. Rusk, both of New York, on "Rehabilitation in Cardiovascular Disease" and Clark H. Millikan, Rochester, Minnesota, on "Cerebral Atherosclerosis and The Concept of Cerebral Vasospasm."

**Personal.**—Dr. Samuel M. Feinberg, professor of medicine at Northwestern University medical school, was installed as president of the International Association of Allergology at its meeting in Rio de Janeiro, Brazil, November 10, 1955. Dr. Feinberg will serve in this capacity for four years. The group is composed of thirty national societies, according to a release from Northwestern University.

**Course in Electrocardiographic Interpretation.**—Beginning February 8, a course in electrocardiographic interpretation for graduate physicians will be given at the Michael Reese Hospital by Dr. Louis N. Katz, director of the cardiovascular department. The class will run for twelve weeks. Additional information may be obtained from Mrs. Ana Rose, administrative secretary, cardiovascular department, Medical Research Institute, Michael Reese Hospital, Chicago 16, Illinois.

**Superintendent Willis Makes Annual Report.**—"We Build the Elementary School an Educational Program" is the title of an attractive thirty-two page booklet making up the annual report of Benjamin C. Willis, general superintendent of schools of the city of Chicago for the year 1954-1955. The booklet is well illustrated with accompanying text discussing the various activities carried on in the Chicago Public Schools. One section, titled "Adequate Support", reveals the interesting gross of the elementary school membership and carries a break down for the school budget dollar. The material is well organized and informative.

**Multiple Sclerosis Clinic.**—A clinic for multiple sclerosis patients was recently opened at St. Luke's Hospital under the direction of Dr. Roland P. Mackay. The clinic is under the auspices of the Chicago chapter of the National Multiple Sclerosis Society, 53 West Jackson Boulevard. Dr. Donald D. Layton, resident neurologist at St. Luke's, is assisting Dr. Mackay. Clinic sessions are conducted on Tuesday mornings and Friday afternoons. Applicants should request referral or sanction from their physicians before applying for admission. Any member of the Chicago chapter of the society or patients residing within the metropolitan area of Chicago may apply for admission.

**Personal.**—Dr. Arthur E. Mahle has been elected chief of staff at Chicago Wesley Memorial Hospital, succeeding Dr. H. Ivan Sippy. Others elected at the staff's annual meeting were: Dr. Joseph F. Mallach, vice chief of staff; Dr. Edward M. Dorr, secretary-treasurer; Dr. Samuel J. Fogelson, Dr. Norman G. Parry, and Dr. Sippy, members at large, and Dr. Mahle, Dr. Fogelson, and Dr. George H. Gardner, liaison committee.

**Walter Barnes Announces Retirement.**—Dr. Walter S. Barnes, formerly chief surgeon at Mercy Hospital where he is an honorary staff member, observed his 87th birthday, January 14. In an interview with the Chicago Daily News, Dr. Barnes stated that he thought this age was about the time he should stop practice but that he planned to wait until his office lease expired May 1. "My hand's as steady as a rock but my vision is going back on me", Dr. Barnes is reported to have said. He continued "Nowadays I just take care of my old patients, the ones who have taken care of me over the years. And I see them only by appointment."

**Michael Reese Honors Staff Physicians.**—Bronze plaques acknowledging thirty or more years of service were awarded to eight physicians at the annual meeting of the Michael Reese medical center staff, January 19. Physicians who received awards were: Ralph B. Bettman, William A. Brams, Eugene P. Lieberthal, Ralph A. Reis, Harry C. Rolnick, Alfred A. Strauss, Irving F. Stein and Erwin P. Zeisler.

**Science Writers Honored.**—Roy J. Gibbons, science editor of the Chicago Tribune, was presented with a copy of a resolution adopted by the council of the Chicago Medical Society, January 9, commending the Chicago Tribune for a series of six articles by him describing medical care available in Chicago. The presentation was made by Dr. Maurice M. Hoeltgen, president of the Chicago Medical Society. "The articles," said the resolution, "provide an accurate and intelligent description of the high standard of professional services avail-

able and provided in a great variety of conditions . . . such articles, instead of incurring dissatisfaction, despair and criticism in the minds of the public, must offer encouragement to many people, and inspire confidence in the medical profession." The series related the intimate case histories of disabled patients restored to new lives of usefulness thru physical medicine and rehabilitation. "Be it resolved," the resolution added, "that the Chicago Medical Society commend Roy J. Gibbons, for having produced this valuable and accurate series."

Arthur J. Snider, science editor of the Chicago Daily News, was awarded a citation of merit by the Illinois Civil Defense Agency, January 10. The award cited Snider for his "outstanding services in preparing special articles on the hazards of radioactive fallout . . . thereby prompting public attention to the increased needs for civil defense."

Robert M. Woodward, state civil defense director, made the presentation in Civil Defense Agency offices in the U. S. Courthouse.

He said Snider was the first science writer to recognize and write about dangers of radioactive fallout.

Snider was one of 30 newsmen from newspapers, radio and TV stations in Chicago and downstate to get awards.

## FORD

**Funds Raised Through Voluntary Effort.**—The Ford County March of Dimes campaign was given a big boost when the chairman, Mrs. Glenn Foster of Paxton, received a check for $791 from the Ford County Medical Society.

The check represented a surplus of voluntary contributions of a dollar each from the grade school pupils who received Salk polio vaccine shots. Each child receiving the series was asked to donate $1 to cover expenses for equipment and material.

However, syringes, needles and other supplies were donated by another organization, and the money was not needed. The Medical Society then decided to give the money to the county March of Dimes drive, in behalf of the Ford county children.

Dr. Ross Hutchison, Gibson City, represented the society at the presentation.

## KNOX

**Personal.**— Drs. J. W. Packard and Robert Reed were recently elected to membership in the Knox County Medical Society.

## LAKE

**Personal.**—Dr. Bruce Bairstow, Waukegan, has been elected to membership in the Lake County Medical Society.

**Abbott Laboratories Entertains Professions in Special Anniversary.**—Abbott Laboratories sponsored a dinner in the auditorium of the Abbott research building, February 29, to commemorate the golden anniversary of the Congressional Acts which established the guidelines within which wholesome food and reliable drugs could be produced and used with confidence. Members of the Lake County Medical Society, together with distinguished representatives of other professions interested in the functioning of the U. S. Food and Drug Laws were guests. A panel discussion on "50 Years' Progress under Food and Drug Laws" was carried on by the following: The Honorable George P. Larrick, Commissioner of the Food and Drug Administration, Austin Smith, M. D., Editor of the Journal of the American Medical Association; Robert L. Swain, Ph. D., Editor of Drug Topics and Chairman of the Board of Trustees of the United States Pharmacopeia; and Thomas Austern, General Counsel for the National Canners Association.

**Society News.**—Dr. Morris Fishbein, Chicago, addressed the Waukegan Elk's Club and the Waukegan Rotary Club, February 22. Members of the Lake County Medical Society were invited to attend this joint dinner meeting.

## PEORIA

**Society News.**—Dr. William Riker, member of the staff of Children's Memorial Hospital, Chicago, addressed the Peoria Medical Society, January 17, on "Surgical Emergencies in Infancy and Childhood."

## ST. CLAIR

**Society News.**—Dr. John Deyton, medical director of Miriam Rehabilitation Division of the Jewish Hospital, St. Louis, addressed the St. Clair County Medical Society, February 2, on "The Role of the Physiatrist as a Consultant in the Management of Rehabilitation Problems."

## SANGAMON

**Roland Cross Honored.**—Honorary membership in the Sangamon County Medical Society was awarded to Dr. Roland Cross, director of the Illinois Department of Public Health. The certificate was presented at a dinner meeting January 5 in recognition of the outstanding accomplishments of the Illinois Department of Public Health during his sixteen years tenure as director. Dr. David J. Lewis, retiring president of the County Medical Society, presented the certificate which read: "Sangamon County Medical Society by a vote of its membership awards Dr. Roland R. Cross this certificate of Honoary Membership in recognition of his outstanding achievements in the realm of medicine; his high qualifications, personal and professional; and his high professional standing which has resulted from the dedication of his abilities to improving medical care."

In accepting the citation, Doctor Cross remarked: "I am deeply grateful for the honor you have conferred on me. I know that it is very unusual for a medical society in this State to award an honorary membership to anyone and more unusual to so recognize a physician who is still fully active in his practice or position. I am mindful too of the well founded observation of the Great Teacher that 'A prophet is not without honor save in his own country and in his own house.' "That you have

seen fit to honor me, who is one among you, and to have done it in a most unusual way, fills me with humble pride. Indeed I can think of no other recognition outside of my immediate family that would mean so much to me as the action which this group of my fellow physicians has taken here tonight.

"In accepting honorary membership in the Sangamon County Medical Society I feel impelled to pay tribute to the devoted efficiency, loyalty and high integrity of the fine staff of men and women in the State Department of Public Health who have made possible any success which has been achieved by that Department during my incumbency. There is no finer group of people on earth than those employed by the Illinois Department of Public Health. All of the professional and technical personnel have been educated especially for the kinds of work they are doing. Many of them hold doctorate degrees and many others have masters degrees in their specialties. They know what to do and how to do the things which need to be done in protecting and improving the public health. And they are exceedingly industrious. Above all they know how to get along with people so as to get things done willingly, cooperatively and in good spirit.

"I say then, that you honor them in honoring me and I am glad of the opportunity of paying tribute of them now.

"I would be remiss in my duty if I did not mention also the important contribution which the medical profession has made toward the successful operation of the Illinois Department of Public Health. The cooperation, the manifestation of mutual confidence and the spirit of good will of the medical profession, both as individuals and as an organization, have been outstanding and of immense importance throughout my incumbency. This splendid relationship is a fine demonstration of the strength and value of teamwork that may be attained by governmental and voluntary agencies in getting things done in the public interest when there is a will to do so. The relationship which prevails between the profession and the Department has been responsible in large part for the advancement of public health in Illinois to a degree which is the envy of health officers in many other states. I am proud of the record and I cherish the good will and the confidence of the medical profession which has done so much to make that record possible.

"So with abundant gratitude and in humble spirit I accept the honorary membership in the Sangamon County Medical Society and I pledge to you that it will be a steadfast reminder to me to do the very best I can as long as I can to justify in full measure the confidence implicit in the honor you have conferred on me."

**Society News.**—Dr. F. Garm Norbury, Jacksonville, president of the Illinois State Medical Society, addressed the Sangamon County Medical Society at the Elks Club, February 2, in Springfield. His subject was "Tranquilizing Drugs." Floyd E. Tarbert, executive secretary of the Winnebago County Medical Society, Rockford, also spoke on the "Functions of a County Medical Society Executive Secretary."

## GENERAL

**Heart Groups Open Campaign For Funds.**—The American Heart Association and the Chicago Heart Association opened their 1956 national campaign kick-off with a dinner in the grand ballroom of the Palmer House, January 31. Speakers included: Hon. Richard J. Daley, Mayor, city of Chicago; Louis N. Katz, M. D., president of the Chicago Heart Association; Dr. Preston Bradley, Pastor of the Peoples Church of Chicago; Irvine H. Page, M. D., president of the American Heart Association; Sylvester L. Weaver, Jr., chairman of the board, National Broadcasting Company; Paul Dudley White, M. D., eminent Boston cardiologist; Robert E. Hunt, vice-president of the Northern Trust Company and Bruce Barton, chairman of the board, Batten, Barton, Durstine & Osborn.

**Commission Sponsors Meeting on the Handicapped Child.**—"Sharing the Community With the Handicapped Child" was the theme of a Regional Conference on Exceptional Children in Quincy recently, which was sponsored by the Illinois Commission for Handicapped Children and attended by more than 200 persons from the six-county area. Dr. Raymond E. Robertson, superintendent of the Institute for Juvenile Research gave the luncheon address on "Mental Health and the Handicapped Child." The program included a panel discussion on sharing with handicapped children opportunities for achievement, for fun and for acceptance, followed by three "do-it-ourselves" workshops on the practical application at the local level. Among the physician participants were: Drs. George Bordon, chairman of the Mental Health Association of Quincy, and Otto Berdach, clinic director of the Jacksonville State Hospital. Drs. Otto L. Bettag, director of the Department of Public Welfare; Edward L. Compere, professor of bone and joint surgery at Northwestern University Medical School, and Roland R. Cross, director of the Illinois Department of Public Health, are members of the Illinois Commission for Handicapped Children, a state agency since 1941 with responsibility to study the needs of the physically and mentally handicapped children of Illinois and to promote an adequate program of service for them. The Commission has offices at 160 North LaSalle Street, Chicago. Miss Jane Bull is executive director.

**Sectional Meeting of College of Surgeons in Milwaukee.**—Handling of mass casualties was one of the important subjects discussed by a panel of experts at the Sectional Meeting of the American College of Surgeons during the three-day meeting in Milwaukee, February 27 through 29, at the Hotel Schroeder. Dr. Forrester W. Raine, Milwaukee, was Chairman of the Advisory Committee on Arrangements.

Among the topics considered were fractures in children, hypothermia in cardiac and general surgery, carcinoma of the prostate, tumors of the thyroid, cancer of the colon, intestinal obstruction, problems in operability, endometriosis, repair of nasal defects, and biliary tract surgery. Special hospital clinics were offered on two mornings of this meeting. Medical motion pictures and cine clinic films were included in the program. Illinois physicians participating in the meeting included: R. Kennedy Gilchrist, Chicago, Harry W. Southwick, Warren H. Cole, Ralph A. Reis, George H. Gardner, Derrick Vail, Samuel Meyer, H. William Scott, Jr., Jospeh P. Evans and Dwight E. Clark, all of Chicago.

**Postgraduate Conference.**—The Richland County Medical Society acted as host for a Postgraduate conference in Olney, January 26, presented by the Postgraduate Education Committee of the Illinois State Medical Society in cooperation with the faculty of the University of Illinois College of Medicine. Speakers were: Drs. James A. Schoenberger, on "What's New in Medicine"; William J. Grove, on "What's New in Surgery"; Rocco V. Lobraico, Jr., on "What's New in Obstetrics and Gynecology" and Heyworth N. Sanford, on "What's New in Pediatrics".

**Meeting of Illinois Pathologists.**—The fall meeting of the Illinois Society of Pathologists was held at the University of Illinois College of Medicine, December 3. Speakers were Drs. Paul B. Szanto, associate director of the department of pathology at Cook County Hospital on "Inflammatory, and Neoplastic Lesions of the Upper Respiratory and Digestive Tracts." and Louis R. Limarzi, associate professor of medicine, at Illinois, on "Interpretation of Bone Marrow Smear." Officers of the society are Drs. Jerry J. Kearns, president, and Frederick C. Bauer, Jr., secretary-treasurer.

**"Your Doctor Speaks" on FM Station WFJL.**—The following physicians have recently appeared in transcribed broadcasts of **FM Station WFJL, Thursday evenings at 7:45 p.m.** The series, entitled **"Your Doctor Speaks,"** is presented by the **Educational Committee** of the **Illinois State Medical Society:**

**Danford C. Chamberlain,** attending urologist at Augustana Hospital, January 26, 1956, on Hematuria.

**William J. Schnute,** assistant professor of surgery, Northwestern University Medical School, February 23, on Injuries During the Growth Period.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Alan R. Feinberg,** currently instructor in Medicine, Northwestern University Medical School, Woman's Auxiliary to the Tazewell County Medical Society and the Pekin Woman's Club, March 2, on Allergy.

**Adrien Ver Brugghen,** clinical professor of surgery, University of Illinois College of Medicine, District Health Chairmen of the Illinois Federation of Women's Clubs, March 9, on Muscular Dystrophy.

**Rudolph Dreikurs,** professor of psychiatry, Chicago Medical School, Philip Rogers Parent-Teacher Association, March 12, on Physical and Emotional Needs of the Child.

**Paul H. Brown, D. D. S.,** a member of the Chicago Dental Society, Philip Rogers Parent-Teacher Association, March 12, on Physical and Emotional Needs of the Child.

**Lawrence Breslow,** clinical assistant professor of pediatrics, University of Illinois College of Medicine, Philip Rogers Parent-Teacher Association, March 12, on Physical and Emotional Needs of the Child.

**Marvin A. Rosner,** clinical assistant in obstetrics and gynecology, University of Illinois College of Medicine, Victor F. Lawson Parent-Teacher Association, March 13, on Answering the Child's Sex Questions.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**George E. Hall, J. D.,** staff associate at the American Medical Association, Marion County Medical Society, Centralia, February 16, on Malpractice, Incidence, Causes, Prevention.

**John T. Reynolds,** associate professor of surgery, University of Illinois College of Medicine, Kankakee County Medical Society, Kankakee, February 21, on Intestinal Obstruction From a Surgical Standpoint.

## DEATHS

**Elizabeth B. Ball***, retired, Springfield, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1907, died January 1, aged 73. She was associated with the Illinois Department of Public Health for 25 years.

**Harrison C. Blankmeyer***, Springfield, who graduated at Northwestern University Medical School in 1905, died December 31, aged 78. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

**Spencer P. Blim***, Chicago Heights, who graduated at the Chicago College of Medicine and Surgery in 1916, died January 25, aged 62. He had practiced medicine in the suburb for 35 years.

**Gordon G. Burdick***, Chicago, who graduated at Northwestern University Medical School in 1890, died January 17, aged 90.

**John Wesley Clayton***, Johnston City, who graduated at St. Louis University School of Medicine in 1904, died November 10, aged 80. He served as a member of the high school board and one term as city alderman.

*Member of the Illinois State Medical Society.

**Harvey A. Felts***, Marion, who graduated at Northwestern University Medical School in 1913, died January 7, aged 71. He was a former vice-president of the Ilinois State Medical Society.

**Frank H. First***, Rock Island, who graduated at Rush Medical College in 1897, died recently, aged 85.

**Joseph W. Kadzewick**, Chicago, who graduated at Loyola University School of Medicine in 1932, died January 26, aged 50. He was a member of the staff of Holy Cross Hospital.

**Malcolm T. MacEachern***, Chicago, who graduated at McGill University Faculty of Medicine, Quebec, Canada, in 1910, died February 3, aged 74. He was director of professional relations of the American Hospital Association at the time of his death, and director emeritus of the American College of Surgeons.

**Barney Joseph Marxer***, Dupo, who graduated at St. Louis College of Physicians and Surgeons in 1908, died November 16, aged 72, of coronary thrombosis. He was past-president of the St. Clair County Medical Society.

**George H. Miller***, Bellaire, Michigan, formerly of Chicago, who graduated at the University of Pennsylvania School of Medicine in 1917, died November 13, aged 69.

**Edward H. Ochsner***, retired, Chicago, who graduated at Rush Medical College in 1894, died January 22, aged 88. He was a past president of the Illinois State Medical Society, and former attending surgeon at the Augustana Hospital.

**Charles H. Parkes***, Sharon, Wisconsin, formerly of Chicago, who graduated at Rush Medical College in 1897, died December 10, aged 84.

**John Peters***, Oak Park, who graduated at the Chicago College of Medicine and Surgery in 1912, died January 29, aged 65. He was chief of the medical staff at Oak Park Hospital and former Maywood Health Commissioner.

**Helga M. Ruud***, retired, Chicago, who graduated at Northwestern University Woman's Medical School in 1889, died January 29, aged 95. She had been on the staff of the Norwegian-American Hospital since 1896 and had taught in the nurses' school there for 34 years.

**George H. Stacy***, Peoria, who graduated at Northwestern University Medical School in 1908, died January 22, aged 77.

**Michael H. Streicher***, Chicago, who graduated at the University of Illinois College of Medicine in 1926, died February 9, aged 58. He had been executive secretary and treasurer of the Medical Alumni Association of the College since 1924, except for 1949 and 1950, when he was president.

**Mary E. Williams***, Chicago, who graduated at the University of Illinois College of Medicine in 1917, died recently aged 72. She was a member of the staff of the Women's and Children's Hospital.

**Evelyn N. Young**, retired, Chicago, who graduated at Jenner Medical College in 1913, died January 19, aged 79. She worked for many years for the Chicago Board of Education as an instructor of subnormal children.

*Indicates member of the Illinois State Medical Society.

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## Joint returns

Many physicians will find it to their advantage to file joint returns with their wives, whether or not the spouse has an income of her own. An unmarried person who qualifies as "head of the household" may claim about one-half the tax benefit afforded a married couple on a joint return. *Tax Roundup for Physicians. Ohio M.J. Dec. 1955.*

## Toxic reactions

A rather profound depression and parkinsonian syndrome occurred in a patient receiving whole root Rauwolfia Serpentina in a commonly used dosage. Slow reversal of these symptoms followed the withdrawal of the drug. Some nonintention tremor was still evident five months later. *Harold H. Jones, Jr., M.D. Treatment of Hypertension with Rauwolfia. J. Oklahoma M.A. Nov. 1955.*

*blue at breakfast?*

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*stops morning sickness ...often "within a few hours"*[1]

Fifteen investigators have now confirmed BONADOXIN's efficacy. In 287 patients treated for nausea and vomiting of pregnancy, BONADOXIN was "of great benefit in 90.8% of the cases." Complete relief was often afforded "within a few hours."[1]

Each BONADOXIN tablet contains:

Meclizine HCl.....25 mg.
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Mild cases: One BONADOXIN tablet at bedtime. Severe cases: One at bedtime and on arising.

In bottles of 25 and 100, prescription only. Also indicated in post-radiation sickness, nausea following surgery, Ménière's syndrome.




1. Groskloss, H. H. et al.: Bonadoxin®: a unique control for nausea and vomiting of pregnancy. Clin. Med.: 2:885 (Sept.) 1955.

# BOOK REVIEWS



THE MECHANISMS OF HEALING IN HUMAN WOUNDS. A Correlation of the Clinical and Tissue Factors Involved in the Healing of Human Surgical Wounds, Burns, Ulcers, and Donor Sites. Editor: Shattuck W. Hartwell, B.S., M.S., M.D., Ph.D. in Surgery, Chief of the Surgical Service, Mercy Hospital, Muskegon, Michigan. Charles C. Thomas, Springfield, Illinois. Pp. 116, 1955, 166 pages $4.75.

This monograph, one of the American Lecture Series, provides an interesting approach to wound healing in humans which the author believes differs from wound healing in animals. The author believes that lymphocytes provide the fibro-producing material for the healing of human wounds and that fat is extremely important, not only as a framework for healing but for the production of chemicals necessary for healing. The importance of physical forces acting on a wound is emphasized, re-establishment of functional planes in surgical closure rather than simple approximation to cut-end being the single most significant factor. The book makes interesting reading and should stimulate additional research along these lines.

J.C.S.

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SEGMENTAL ANATOMY OF THE LUNGS. A study of the patterns of the Segmental Bronchi and Related Pulmonary Vessels. Edward A. Boyden, Ph.D. (Med. Sec.) Professor Emeritus of Anatomy, The Medical School, University of Minnesota. The Blakiston Division, McGraw-Hill Book Company, Inc. New York, Toronto, London, 276 pages, Price $15.00.

This book is probably primarily an anatomy. An anatomy of the lungs. But, this is a detailed anatomy. And with all its attention to the minute it is all the while "clinically oriented."

The enormous amount of labor and effort that was required to perfect the factual data and dissections for this volume can only be imagined. Previous literature provided only one dimensional information for the use of the radiologist, the bronchoscopist, internist, or medical student or physicians.

Advances in thoracic surgery, and the development of the techniques of pulmonary resection have brought an urgent demand for greater knowledge of lung structure and accurate information on the boundaries of the segments and the distribution of the branches of the bronchi and blood vessels. Such needed accurate knowledge is provided by Dr. Boyden in this volume.

With the assistance of others, to whom Dr. Boyden gives credit, after stupendous effort this book is presented.

This is no reading matter for easy perusal, it requires specific concentration in order to understand its content.

Dr. Boyden has produced an invaluable contribution, a segmental anatomy of the lungs. The diagrams and illustrations are splendid and quite numerous. These are also produced in color to better distinguish veins, arteries and bronchi.

The relative positions and directions of all structures within the lungs are described and diagrammed. And not only in a single plane, but in different planes all "on" the same "spot". And then the diagram is explained more defi-

(*Continued on page* 56)



No matter how you measure it, AUREOMYCIN* Chlortetracycline can claim a distinguished record: in terms of published clinical trials—there are more than 8,000; as for actual doses administered—the figure is more than a *billion*.

But the most significant fact is told by time. For eight years, AUREOMYCIN has been in daily use, repeatedly employed by thousands of physicians throughout the world. Again and again, it has proved to be a reliable broad-spectrum antibiotic: well-tolerated, prompt in action, effective in controlling many kinds of infection.

***A convenient dosage form for every medical requirement.***

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AUREOMYCIN SF Capsules, 250 mg.

Chlortetracycline with Stress Formula Vitamins.

For Patients with Prolonged Illness AUREOMYCIN SF combines effective antibiotic action with Stress Formula vitamin supplementation to shorten convalescence and hasten recovery. One capsule, q.i.d. supplies one gram of AUREOMYCIN, and B complex, C and K vitamins in the Stress Formula suggested by the National Research Council. AUREOMYCIN SF Capsules are dry-filled and sealed, contain no oils or paste.

*Each capsule contains:*

| | | | |
|---|---|---|---|
| AUREOMYCIN Chlortetracycline | 250 mg. | Pyridoxine ($B_6$) | 0.5 mg. |
| Ascorbic Acid (C) | 75 mg. | Folic Acid | 0.375 mg. |
| Thiamine Mononitrate ($B_1$) | 2.5 mg. | Calcium Pantothenate | 5 mg. |
| Riboflavin ($B_2$) | 2.5 mg. | Vitamin K (Menadione) | 0.5 mg. |
| Niacinamide | 25 mg. | Vitamin $B_{12}$ | 1 mcgm. |

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THE SOURCE
OF RE-INFECTION
CAN BE

# THE HUSBAND

IN VAGINAL
TRICHOMONIASIS



"THE available evidence indicates that one of every four or five adult women harbor the parasite."[1] In many cases coitus must be regarded as a method of transfer.[2]

*Infests the male, too* — "The infestation in males is probably more common than realized and will more frequently be recognized. . . ."[3] Karnaky reports the infection in the urethra, in the prostate or under the prepuce of 38 among 150 husbands with infected wives.[4]

*Symptoms often absent* — In the female, trichomonas vaginitis is a well recognized condition . . . but in the infected males signs and symptoms are usually absent.[2] Or the infection causes little concern because it is transient and mild.

*Prevent re-infection* — "Eradication of the parasites in both sexual partners is of course ideal . . . obviously a condom is the most effective mechanical barrier."[1]

*Prescription of condoms* — To prevent re-infection take special measures to win the cooperation of the husband when you prescribe use of a condom. Writing for *Schmid* condoms assures high quality, makes purchase less embarrassing.

If there is anxiety that the condom might dull sensation, prescribe XXXX (FOUREX)® membrane skins pre-moistened, and like the patient's own skin. For those who prefer a rubber condom, prescribe RAMSES® — transparent, tissue-thin, yet strong.

Suggest use of a condom for four to nine months after the wife is trichomonad-free.

*Treatment of the wife* — The Davis technic† using VAGISEC® liquid explodes trichomonads within 15 seconds of douche contact[5] with "over 90 per cent apparent cures . . ."[6] VAGISEC (originally "Carlendacide") is also available as jelly.

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*References:* 1. Trussell, R. E.: Trichomonas Vaginalis and Trichomoniasis, Springfield, Ill., Charles C Thomas, 1947. 2. Lanceley, F., and McEntegart, M. G.: Lancet *1*:668 (April 14) 1953. 3. Strain, R. E.: J. Urol. *54*:483 (Nov.) 1945. 4. Karnaky, K. J.: Urol. & Cutan. Rev. *48*:812 (Nov.) 1938. 5. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 6. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955.

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## BOOK REVIEWS (Continued)

nitely by a line drawing lettered correspondingly. To open the book at random, one's first flash impression is that this is geometry or perhaps trigonometry—the lettering on the illustrations and then the description in the text using the letters in reference to the illustration.

The abnormal relationship that may be encountered are also dealt with. It would seem practically impossible for one to propound a question concerning anatomical relationship with any portion of any lobe of a lung that could not be answered in this volume.

And so for the bronchoscopist, the radiologist and the surgeon, this volume presents a compass wherewith to chart his further course.

C. P. B.

‹ ›

BONE & BONES. Fundamentals of Bone Biology by Joseph P. Weinman, M.D., College of Dentistry, University of Illinois. Formerly at School of Dentistry, Loyola University, Chicago and Harry Sciber M.D., D.S.C., School of Dentistry, S.C. School of Dentistry, Loyola University, Chicago. 302 Illustrations, 550 pages. Published by the C. V. Moody Company. East St. Louis Missouri. $13.75

A pathologist and an anatomist have cooperated in the production of this volume. This is the second edition. The first edition printed in 1947, was reprinted in 1948 and again in 1950. Now comes this edition with many revisions and additions that make it a book quite worth while for any physician.

The writers state that they are attempting to treat the normal and the pathologic behavior of the skeleton on the basis of biological principles. This has apparently been neglected in recent books and literature. So the work then proceeds to show the reader from the very elementary beginning how confusion may be avoided concerning bone as a structure and bone as a tissue, are stages of bone development are followed through. The book shows what bone is, how it grows, and what happens to it and/or by it in health and in disease.

Also the text interestingly and clearly considers development deformities, the effect or influences of Endocrines, of vitamins, of tumors, of inflammation and of course, of fractures.

(*Continued on page* 58)




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1. Hyman, S., and Rosenblum, S. H.: Illinois M. J. 104:257, 1953.
2. Piper, C. E., and Nicklas, F. W.: Indust. Med. 23:510, 1954.

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## BOOK REVIEWS (Continued)

Instead of being dull and uninteresting, this book is read with an increasing desire to finish the particular subject. It establishes confidence and deals comprehensively with each item considered.

The section on Idiopathic Lesions of the Skeleton is indeed interesting reading. The descriptions here (as elsewhere in the book) are for the most part composed of short sentences: very concise, very clear and leave no doubt as to the author's ideas. The process of healing of fractures is described minutely and should be mentioned here as being well done.

One must also mention the extensive use of references that is made. There are 41 full pages required to list the references, and these are found at the end of the book.

C. P. B.

‹ ›

CLASSICS OF BIOLOGY. Editor: August Pi Suner. Authorized English Translation by Charles M. Stern. Philosophical Library, New York. Pp. 337, 1955. $7.50.

This small book is a collection of classical first descriptions of matters pertaining to biology, including quotations from about 70 authors. Among them are Aristotle, Bernard, Darwin, Descartes, Freud, Haldane, the Huxleys, Lavoisiers, Mendel, Pasteur, and Virchow. It is somewhat analagous to Major's similar book on Classics in Medicine. The translation from the Spanish is adequate and the book makes interesting reading.

J.C.S.

‹ ›

INSTRUMENTATION. Editor: Roy Waldo Miner. Annals of The New York Academy of Sciences. Volume 60; Pp. 807-964, 1955. $3.00.

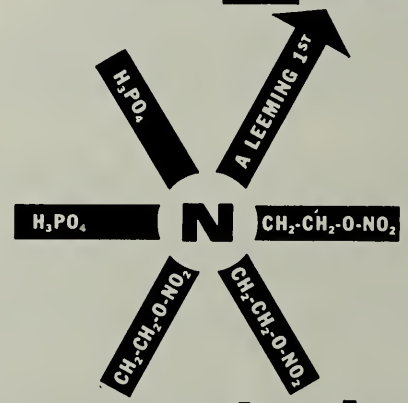
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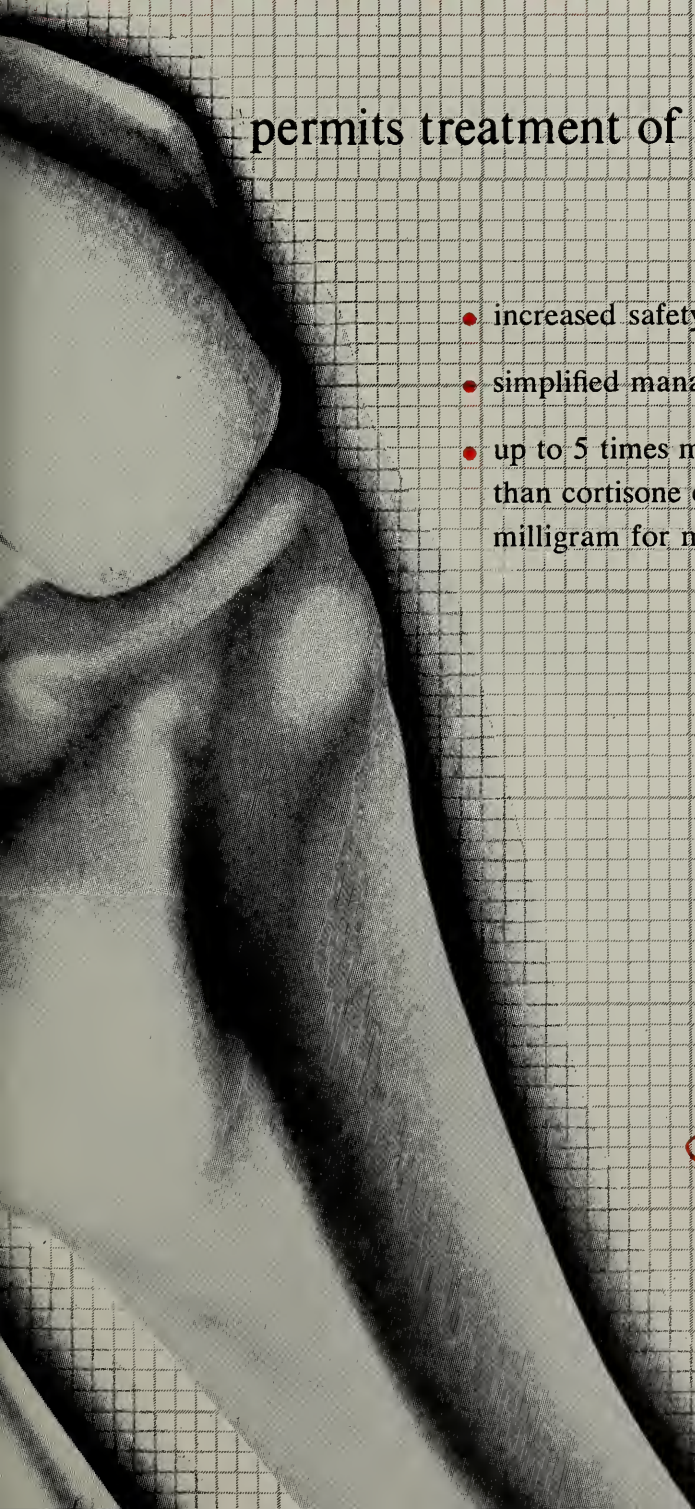
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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

CIBA FOUNDATION SYMPOSIUM ON EXPERIMENTAL TUBERCULOSIS BACILLUS AND HOST. With an Addendum on Leprosy. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O. B. E., M. A., M. B., B. Ch., and Margaret P. Cameron, M. A., A. B. L. S., assisted by Cecilia M. O'Connor, B. Sc., with 69 illustrations. Little, Brown and Company, Boston, 1955. $9.00.

PERSONAL HEALTH MEASURES AND IMMUNIZATION. Medical Department, United States Army. Preventive Medicine in World War II, Volume III. Editor in Chief, Colonel John Boyd Coates, Jr., MC, Editor for Preventive Medicine, Ebbe Curtis Hoff, Ph.D., M.D., Assistant Editor, Phebe M. Hoff, M. A. Office of the Surgeon General, Department of the Army, Washington, D. C., 1955.

PATHOLOGIC PHYSIOLOGY, Mechanisms of Disease. Edited by: William A. Soderman, M.D., F. A. C. P., Professor of Medicine and Chairman of the Department of Medicine, School of Medicine, University of Missouri, Columbia, Mo. Second Edition. 963 pages. 173 illustrations. Publication date, January 10, 1956. W. B. Saunders Company, Philadelphia and London, $13.00.

HANDBOOK OF TOXICOLOGY, Volume 1, Acute Toxicities of Solids, Liquids and Gases to Laboratory Animals. Edited by: William S. Spector. Prepared under the direction of the Committee on Handbook of Biological Data. Division of Biology and Agriculture; The National Academy of Sciences; The National Research Council. 408 pages. Publication date, January 4, 1956. W. B. Saunders Company, Philadelphia and London, $7.00.

THE INTERPRETATION OF THE UNIPOLAR ELECTROCARDIOGRAM. Illustrated. By Gordon B. Myers, M.D., Professor of Medicine, Wayne University College of Medicine; Head, Department of Medicine, City of Detroit Receiving Hospital. The C. V. Mosby Company, St. Louis, 1956. $4.75.

‹ ›

## Economical care

When asked why the board was dropping 33 employees next year, he (Dr. Herman N. Bundesen) retorted: "They were employees in the contagious disease department. When we found individuals reading newspapers on the job we eliminated them. I'm not going to go out and get more diseases just to give these men jobs." *Chicago Tribune, Nov.* 15, 1955.





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## Palliative cancer remedies

There are now, as always, a variety of cancer cures or cancer palliations available for those who must take arms and fight vigorously against this disease. Some of the least harmful and most persuasive are those which, though sponsored by eminent medical men, are pure quackery, secret nostrums clothed with the verbiage of electrochemistry or immunology. Others involve heavy radiation therapy, potent cell poisons, or steroid hormones. We believe that cortisone or similar therapy is more effective and less harmful in palliative management, and that rauwolfia or chlorpromazine may prove invaluable in individual cases in fortifying the patient against pain or despondency. For another patient, whisky and morphine may prove the best therapy. *William Dock. Cancer of the Stomach. Rocky Mountain M.J. Dec. 1955.*

‹ ›

## School examinations

Most schools do, and all schools should notify the parents that the school health examination is to be done during a certain period and that the examination may be done by the family's own physician. If the parents elect to have the examination done by their own physician a notice is sent to the physician. The actual report and examination are no more than are consistent with any conscientious examination given by a physician to any child. For purposes of clarity it should be understood that the school health examination is that phase of the health appraisal that is conducted by physicians and dentists. *Kenneth L. Maclachlan, M.D. School Health and the Family Physician. New England J. Med. Nov. 3, 1955.*

‹ ›

Now that bovine tuberculosis has been all but wiped out in this country, man himself is the source of practically all infection. . . .It can be accepted as a fact that infection with tubercle bacilli commonly results in necrotic lesions which, even though not ordinarily detectable, persist and remain infected for a long period of time. Since tuberculin surveys clearly show that a large percentage of adults have been infected, it is prudent to assume that many of them still carry virulent bacilli. Rene J. Dubos, Ph.D., Nat. Tuberc. A. Tr., May, 1954.

# Meat...

## *and the Value of Fat in Nutrition*

Authorities in the field of nutrition no longer consider fat as an optional component of the diet. Evidence from the laboratory and bedside indicates that fat in small amounts may be looked upon as an obligatory constituent of a health-promoting diet.[1]

The far-reaching value of fat in nutrition has been amply demonstrated in laboratory animals in its pronounced effect on growth, on pregnancy and lactation, on nitrogen-sparing action, on work capacity, on time of sexual maturity, on the period of survival during fasting, and on ability to combat external stresses.[1]

Young animals fed a fat-free diet not only fail to grow normally, but develop hair and skin changes characteristic of "essential" fatty acid deficiency.[2] Fatty acids other than the "essential" fatty acids also appear to be necessary for optimal health. Animals fed "essential" fatty acids but no others do not grow optimally.

The value of fat in human nutrition was emphasized in a recent study[2] comprising 200 patients incapable of receiving adequate nourishment. For periods of 1 to 30 days, these patients were given supplementary fat alimentation by vein in the form of fat emulsion containing "essential" as well as other fatty acids. The result was typically a marked increase in weight and more positive nitrogen and potassium balances.

Meat, recognized for its high content of biologically valuable protein, B vitamins, and essential minerals, provides, in addition, substantial amounts of nutritionally important fat.

1. Deuel, H. J., Jr.: Newer Concepts of the Role of Fats and of the Essential Fatty Acids in the Diet, Food Res. *20*:81 (Jan.-Feb.) 1955.

2. Meng, H. C.: Preparation, Utilization, and Importance of Neutral Fat Emulsion in Intravenous Alimentation, in Najjar, V. A.: Fat Metabolism, Baltimore, The Johns Hopkins Press, 1954, pp. 69-92.

The nutritional statements in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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## Coin lesions

A particularly interesting pulmonary lesion is the so-called coin lesion. This occurs frequently when least expected since the patient usually is asymptomatic and is enjoying relatively good health. Such a finding might be considered inconsequential and might lull the physician into adopting an attitude of inactive observation, particularly since the patient is manifesting no symptoms. However, one should not adopt such a passive attitude but should make a determined effort to arrive at a definite diagnosis since there is a significant incidence of malignancy in such lesions. *C. G. McEachern, M.D. Pulmonary Coin Lesions. J. Indiana M.A. Nov. 1955.*

‹ ›

## Colon cancer

The chief clinical sign of malignancies in the right half of the colon is a peculiar type of anemia which, symptomatically, is not unlike pernicious anemia. So constant is its presence to some degree that cancer should be suspected immediately if no other source of blood loss is found. Insidious in onset, the anemia is exhibited first by a general weakness; in fact, this weakness may at times be the sole clue to the diagnosis. Gradually, anemia and weakness become more profound and are accompanied by loss of appetite and weight and by toxic symptoms incident to the absorption of poisonous substances from the ulcerated and infected surfaces of the growth. As the tumor enlarges and ulceration and infection increase, the patient approaches a state of cachexia. Before this stage is reached, however, other evidences of the disease will have entered the picture. *R. L. Sanders, M.D. Cancer of the Colon. Texas J. Med. Nov. 1955.*

‹ ›

At this moment, it is exceedingly important that the decrease in the number of new cases of clinical tuberculosis evolving and the precipitous decline in mortality are not interpreted as the approach of immediate ultimate victory over tuberculosis. Such an interpretation could play into the hands of the tubercle bacillus, which could soon again become as widespread and destructive as it was in this country fifty years ago. The phenomenal success in reducing morbidity and mortality represents a battle less than half won against the tubercle bacillus. Editorial, J. Arthur Myers, M.D., Journal-Lancet, April, 1955.

# A New Aid To Encourage Better Nutrition Of Older People

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"Diet. The basal diet of the aged should be designed according to the same principles as applied to other adult groups. However, because of the frequently low total consumption of food, it is wise to encourage a liberal intake of protein and other protective foods. Three or four meals per day should be planned. The aged tolerate large meals poorly. Foods with soft bulk should be included. Fats should be restricted according to each patient's tolerance. In general, it is wise to avoid fried and fatty foods." Chapter 13—Drs. William H. Sebrell, Jr., and James M. Hundley, *Geriatric Medicine*, Edited by Edward J. Stieglitz M.S., M.D., F.A.C.P., Third Edition, J. B. Lippincott Company.

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## African infarcts

Elliot had no proved cases admitted over a two year period to 150 medical beds for non-European patients in Johannesburg. One suspected case was found at autospsy to have syphilitic coronary ostial stenosis; one was discharged and not seen again. Grek analyzed 6,000 Bantu patients passing through 65 medical beds in a period of six years. Of 22 cases initially diagnosed as myocardial infarction, 15 were-later attributed to syphilitic coronary ostial stenosis. Of the remaining seven, only three were followed to autopsy, and of these three, only two were attributed to coronary thrombosis. At the same time and place in 8,000 admissions to the European medical wards of the Johannesburg General Hospital, 1950-51, there were 235 cases of coronary thrombosis with myocardial infarction. *John F. Brock, M.D. and B. Bronte-Stewart, M.D., The Internist and Some Tools. Minnesota Med. Dec. 1955.*

‹ ›

## Something new

The Year Book of Medicine usually gives new information on well known diseases but the 1955-56 issue is notable for conditions and methods which are still fairly obscure, e.g., Iceland disease, fibrogenopenia, hypoprothrombinopenia, vectorcardiography of infarction, and primary aldosteronism. . . .The title of a recent UCLA medical lecture also is intriguing: the oligemic syndrome. It wouldn't be hard to connect it up with the word more commonly used for the condition, once you think hard. Shock, that is. *Guillermo Osler, M.D., RX., DX., AND DRS. Arizona Med. Nov. 1955.*

‹ ›

Programs which stand the greatest chance of further reducing morbidity and mortality rates will be those that require an informed and enlightened public—informed to the extent that the individual has certain attitudes and engages in certain actions because he is convinced that he must take these actions to provide the benefits of good health to himself, his family, and his community. Leroy E. Burney, M.D., Am. J. Pub. Health, February, 1955.

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*Dosage:*

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1. Johnston, R.L.: J. Indiana St. M.A. 46:869, 1953. 2. McHardy, G., and Browne, D.: Southern M. J. 45:1139, 1952.

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## The quiet zone

Complaints about noise in hospitals continue to be made and it is now generally accepted that this is a serious problem. The principal reasons for the present noisy conditions are known. There is more nursing and medical activity, with more walking, more transport especially by trolley, more mechanical equipment, and more sanitary fittings. Compact planning has brought the sources of noise nearer to the patient, and the lighter panel walls and partitions of modern framed structures are less resistant to sound than the heavier, solid masonry walls used in the past. A recent survey into the actual cause of ward noises revealed that much of it originates in corridors. The principal causes of noises in daytime appeared to be trolleys and the slamming of doors. It seems almost unbelievable that in one ward, between 9 and 10 a.m., 300 door slams were recorded. The nonabsorbent finishes in the corridors increase reverberation and prevent noise from dying away. The average night levels were attributed to mechanical noises such as running machinery and water or steam pipes. Sanitary appliances, particularly water closets and bedpan washers, also are responsible for considerable ward noise because both often are situated close to the actual bed areas in wards. *John Lister, M.D. By the London Post. New England J. Med. Nov. 24, 1955.*

‹ ›

## A safe spinal

Spinal anesthesia can be safe if it is administered by a physician who is well versed in the fundamental principles of anesthesiology and has a basic knowledge of the anatomy and physiology of the central nervous system. He must be familiar with the pharmacology and dosage of the agents used and should be cognizant of the indications, contraindications, and complications of the method employed. The physician must be willing to observe the patient minutely from the time of induction to the end of the procedure. These prerequisites for a safe spinal anesthesia are mandatory. *Nevin H. Rupp, M.D., Spinal Anesthesia Can Be Safe. Arizona Med. Nov. 1955.*


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## Unwanted hair

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‹ ›

The maintenance of health is immeasurably more important than its restoration after disease has developed. Emil Bogen M.D., Dis. of Chest, September, 1955.

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Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.

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## Abdominal aneurysm

Abdominal pain and the presence of an abdominal mass noted by the patient are the two symptoms of aneurysm of the abdominal aorta most frequently encountered. The pain of aortic aneurysm commonly is a diffuse type of distress in the middle and lower portion of the abdomen or in the lower part of the back. There is a tendency for pain to be more prominent on the left and to extend down the left side of the abdomen. The one common physical sign is an expansile, pulsatile mass in the abdomen. The diagnosis of aneurysm should not be made solely on the basis of this physical finding unless the mass can be grasped by deep pressure with both hands and localized bilateral, expanding pulsation can be felt. Nervous patients complain frequently of abdominal throbbing and pulsation and in such patients, a prominent pulsation may be felt in an aorta of normal size. Patients who have lordotic spinal columns or elderly persons with sclerotic, tortuous aortas may have palpable abdominal pulsations which simulate the pulsations in an aneurysm. A thrill or bruit is present over an aneurysm in only about half of the patients and its presence or absence does not help much in the diagnosis. *Edgar A. Hines, Jr. Clinical Aspects of Arteriosclerotic Aneurysm. Minnesota Med. Dec. 1955.*

‹ ›

## The need for booster doses

Booster doses of tetanus toxoid should be administered routinely at fairly regular intervals, and four year intervals appear satisfactory. A routine booster at any time up to 10 years may restore immunity, and a booster dose of tetanus toxoid may be relied upon in an emergency in any fully immunized person up to 10 years after the last previous toxoid injection. However, in the event of multiple, extensive, or heavily contaminated injuries, especially about the head or neck, uncertainty regarding previous tetanus immunization or delay in administering the emergency booster injection, the simultaneous administration of antitoxin along with the toxoid is justified. *Joseph M. Looney, M.D. et al. Persistence of Antitoxin Levels after Tetanus-Toxoid Inoculation. New England J. Med. Jan. 5.* 1956.

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Big shots are only little shots who keep shooting. — Christopher Morley

The
ILLINOIS
Medical Journal
Official Journal of The Illinois State Medical Society

APRIL, 1956
VOL. 109 NO. 4

# Segmental Pulmonary Resection: A Multi-Purpose Operation

EARL B. SANBORN, M.D., EVANSTON

THE excision of pathological tissue which is irremediable by other means is one of the basic obligations of a surgeon. An important corollary is the preservation of normal functioning tissue. These principles have been advocated by thoughtful and considerate surgeons for a number of years in their conservative excisional therapy of benign lesions for many of the organs of the body. However, it was not until 1939 that these concepts were applied to pulmonary resection. In that year Churchill and Belsey[1] recommended that the bronchopulmonary segment, rather than the lobe or lung, be the unit of surgical therapy. Subsequently the contributions of Overholt[2,3] and Chamberlain[4,5] established the operation known as segmental pulmonary resection.

## ANATOMY

A proper nomenclature of the bronchopulmonary segments was contributed by Jackson and Huber[6] in 1943 (Figure 1). Later Boyden and co-workers[7-12] intensively investigated the bronchovascular variations of these units of the lungs. As a result roentgenologists, pathologists, and clinicians are utilizing this knowledge more frequently in their descriptions of pulmonary lesions.

## CLINICAL MATERIAL

During a six month period the technique of

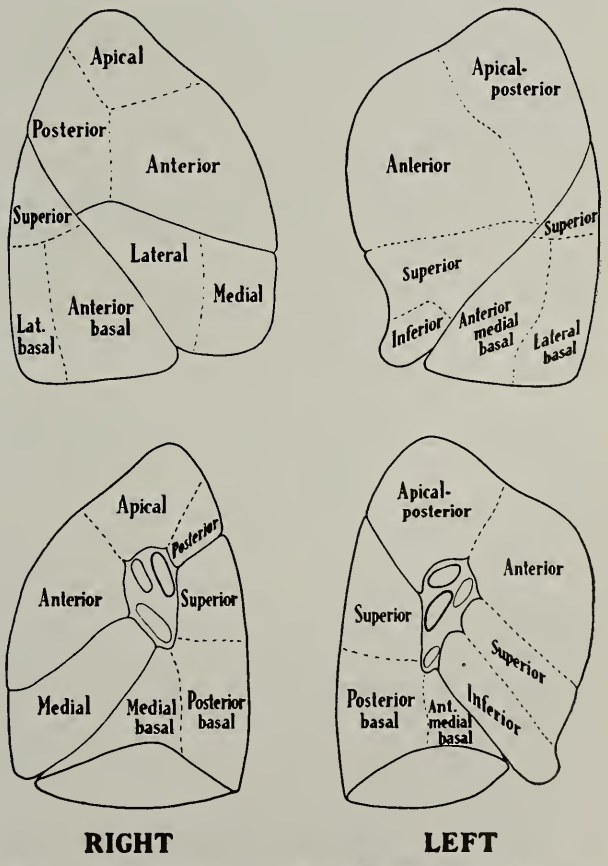



**Figure 1. Bronchopulmonary segments of the lungs (after Jackson and Huber)**

*From the Thoracic Surgical Service of the Veterans Administration Hospital, McKinney, Texas, and The Southwestern Medical School of the University of Texas.*

*Presented to the Central Surgical Association, Detroit, Mich., Feb. 20, 1954.*

TABLE 1. POSTOPERATIVE PATHOLOGICAL DIAGNOSES

| | |
|---|---|
| Nontuberculous Conditions: | |
| Residual cavity after tularemic lung abscess | 1 |
| Bronchiectasis | 2 |
| Chronic lung abscess | 1 |
| Chronic pneumonitis | 1 |
| Tuberculosis | 10 |
| Total Number of Patients | 15 |

TABLE 2. COMPLICATIONS

| | |
|---|---|
| Morbidity: | |
| Subscapular fluid, later infected | 1 |
| Empyema with bronchopleural fistula | 1 |
| Air pocket, requiring reinsertion of intercostal tubes | 2 |
| Spread or reactivation of tuberculosis | 0 |
| Wound infection | 0 |
| Mortality | 0 |

TABLE 3. RESULTS

| | |
|---|---|
| Nontuberculous Patients: | |
| Tularemic lung abscess—well for one year; discharged | 1 |
| Bronchiectasis—well for 2-3 years; working | 2 |
| Chronic lung abscess—well for 3 years; working | 1 |
| Chronic pneumonitis—well for 3 years; working | 1 |
| Tuberculous Patients: | |
| No disease; lost to follow-up after 6 and 12 months | 2 |
| No evidence of disease for 2½-3 years; working | 7 |
| No evidence of activity for 1½ years; not working | 1 |
| Total Number of Patients | 15 |

segmental excision was utilized in 15 patients of a group of 33 having pulmonary resection. Except in two cases, no attempt was made preoperatively to decide the extent of surgery. In these, pathology had been localized to a single bronchopulmonary segment by a bronchogram. In each instance, thoracotomy was first performed. The extent of pathology present, including evaluation of regional lymph nodes, was next determined. Excisional surgery was not performed on the basis of a positive Papanicolaou test of bronchial secretions or sputum alone. Instances are known of a total pneumonectomy having been performed with such an indication and no evidence of neoplasm found in the surgical specimen. In some cases of tuberculosis it was necessary to perform decortication first. Then the decision was made as to the number of bronchopulmonary segments pathologically involved. These were then excised. Even though lobectomy was recommended preoperatively by the medical staff a segmental excision was utilized to remove the involved pulmonary tissue in two cases. In brief, the policy followed was to adjust the operation to the patient rather than adapt the patient to the operation. The pathological diagnoses of this series of patients are given in Table 1.

TABLE 4. SEGMENTAL RESECTIONS PERFORMED

TUBERCULOSIS

| *Patient* | *Date* | *Segments Removed* | *Associated Procedures* |
|---|---|---|---|
| 1. J.R. | 1-19-51 | Apicoposterior of LUL | Bronchoscopy |
| 2. E.M. | 2-14-51 | Superior of LLL | Left upper lobectomy and bronchoscopy |
| | 3- 1-51 | | Partial (modified Estlander) thoracoplasty |
| 3. N.R. | 3- 9-51 | Apicoposterior of LUL | Decortication and bronchoscopy |
| 4. J.S. | 3-14-51 | Apicoposterior of LUL | Decortication and bronchoscopy |
| | 5-25-51 | | Partial (modified Estlander) thoracoplasty |
| 5. T.C. | 3-22-51 | Apical of RUL | |
| 6. S.W. | 4- 6-51 | Superior of RLL | |
| | 5- 9-51 | | Right upper lobectomy and bronchoscopy |
| 7. H.E. | 4-18-51 | Apicoposterior of LUL | Partial (modified Estlander) thoracoplasty |
| 8. D.F. | 4-27-51 | Apical and posterior of RUL | |
| 9. N.R. | 5-23-51 | Apicoposterior of LUL | Wedge excision of RLL and bronchoscopy |
| 10. J.B. | 6-22-51 | Apicoposterior of LUL | Decortication and bronchoscopy |
| | | | Bronchoscopy |

NONTUBERCULOUS CONDITIONS

| | | | |
|---|---|---|---|
| 11. J.A. | 1- 5-51 | Superior of RLL | Tularemic lung abscess with cavitation |
| 12. L.T. | 1-24-51 | Apicoposterior of LUL | Chronic lung abscess (due to broncholithiasis) |
| 13. L.R. | 1-31-51 | Superior of RUL | Chronic fibrosing pneumonitis |
| 14. C.M. | 3-15-51 | Posterior basilar of LLL | Chronic purulent bronchiectasis |
| 15. J.K. | 6-21-51 | Basilar segments of LLL | Chronic purulent bronchiectasis |

## UNDIAGNOSED CONDITIONS

The increasing use of chest X-rays as a routine admission procedure in general hospitals and in mass surveys of tuberculosis control programs, has resulted in the discovery of more pulmonary lesions. Also, the need for earlier diagnosis of bronchogenic carcinoma has developed from a greater incidence of the disease as well as the fact that cancer of the lung has a silent phase, when it masquerades as a viral, chronic, or recurrent pneumonitis.

In addition, since the mortality rate for an exploratory thoracotomy has been reduced by well trained thoracic surgeons until it is negligible, physicians are now more willing to recommend such a procedure. Segmental pulmonary resection by experienced surgeons is an additional argument for operating on small undiagnosed pulmonary lesions. A conservative surgeon can excise a segment or two, depending upon the amount of disease present, and thus preserve more functioning lung, provided the specimen demonstrates no malignant tissue. If malignancy is present lobectomy or radical total pneumonectomy can then be performed, depending upon the situation. Three patients in this series had undiagnosed conditions preoperatively and the bacteriological studies were negative on smear and culture for acid fast bacilli. One (L.T.) was found to have a chronic lung abscess; another, tuberculosis; and a third, chronic pneumonitis (L.R.). (Table 4). They were all males and over 40 and early lung cancer could not be excluded before surgery.

## LUNG ABSCESS

Another situation in which segmental pulmonary resection has proved invaluable is chronic lung abscess. The use of antibiotics has changed the management of the acute lung abscess but surgical drainage still is indicated in some cases. The chronic process is best treated by surgical excision, especially if epithelium has grown into a residual cavity or there is a significant amount of residual pathological tissue. Removal of a bronchopulmonary segment or segments containing the chronic process will conserve functioning lung tissue. Two patients in this group had this condition. One (J.A.) had a rare lesion, a tularemic lung abscess with a residual cavity which had become lined with epithelium that was continuous with that of the tracheobronchial tree. The other (L.T.) was treated for pulmonary tuberculosis for several months before it was decided to get a histological diagnosis, utilizing exploratory thoracotomy. With a definitive diagnosis of chronic lung abscess, hospitalization on the tuberculosis service was no longer necessary. (Table 4).

## BRONCHIECTASIS

The original purpose for which Churchill and Belsey[1] recommended segmental resection was bronchiectasis of the lingula of the left upper lobe. Excision of only the segments involved by bronchiectasis is now an accepted routine. Many patients with bilateral bronchiectasis are treated surgically with good results. Previously they could not have had surgery or would have been respiratory cripples because of the extensive procedures required. One patient (C.M.) in this series had involvement of only the left posterior basal segment. This segment was excised with satisfactory results. Another (J.K.) had bronchiectasis of the four basal segments of the left lower lobe. These were removed and a normal superior segment was left. Both patients had a satisfactory postoperative course and were asymptomatic for two and one-half to three years. (Table 4.)

## TUBERCULOSIS

For a number of years, the treatment of pulmonary tuberculosis was chiefly medical: bed rest and supportive care. Later, surgical procedures, mainly collapse, were utilized for cavitary or extensive fibrocaseous disease. With the widespread use of modern antimicrobial therapy, bed rest has assumed a less important role. Surgery of the excisional type has become more useful in the management of the disease. This has been due to the markedly decreased mortality and morbidity rates in the hands of well trained thoracic surgeons. Removal of unhealed residual tuberculosis decreases the possibility of exacerbation or recurrence.

Some of the best advice received from an older surgeon was that given by Churchill[13]. He said that a surgeon should know or understand the disease which he is to treat surgically, particularly in excisional surgery for pulmonary tuberculosis. A surgeon doing this type of work must know the life history of the disease, the principles of its management, and its gross pathology.

The indications for segmental resection in pulmonary tuberculosis have become more definitive with the passage of time. The disease process

must be localized to the bronchopulmonary segments that are to be excised. Necrotic or caseous lesions and so-called nodular tuberculosis with or without an exudative or pneumonic component are indications for extirpative surgery. A residual cavity confined to one or two bronchopulmonary segments without other significant pathology is an indication for segmental resection. The segments usually involved are those located in the superior and posterior portions of the lobes (Table 4).

All except one patient in this series with postoperative diagnosis of pulmonary tuberculosis had medical treatment for a satisfactory period of time before surgical interference. The one exception has been mentioned earlier in the discussion of the undiagnosed conditions.

Decortication may be necessary before the extent of the pathology can be determined. This was the situation in three patients. Table 4 lists the associated procedures performed in addition to decortication and segmental resection. Bronchoscopy was performed in eight cases at the end of the operation before the patient left the operating room. This insures a patent airway until the patient is able to cough effectively.

In two cases the upper lobe and superior segment of the lower lobe were removed. In one, a left total pneumonectomy would have been much simpler but leaving the four basal segments accomplished two objectives: the patient had more remaining lung tissue and the residual dead space was decreased and, therefore, less of a problem. A partial or tailored thoracoplasty was done in three patients as a second stage procedure. In one of these thoracoplasty was postponed to a second stage because of the patient's condition at the time of the completion of the resection. In two, the indication was to prevent overexpansion of the remaining pulmonary tissue; in the third, it was done because the remaining lung failed to expand owing to interstitial fibrosis (as a result of collapse due to pneumothorax and the resultant thickened visceral pleura).

## TECHNIQUE

The technique utilized in this series of patients will not be described in detail. It was a modification of that published by Overholt[3] and Sweet[14]. Meticulous dissection is necessary to isolate the bronchovascular components of the pulmonary segments. A knowledge of their anatomical variations is absolutely essential.

The complications occurring in this series are listed in Table 2. Postoperative accumulation of small amounts of fluid in the pleural space has not been listed. Aspiration of such fluid was performed in approximately one-third of the patients. Usually one or two aspirations sufficed.

The patient with subscapular fluid left the hospital against advice 15 days after a second stage partial thoracoplasty. Some fluid had been aspirated from the subscapular space postoperatively but there was a residual amount when he left. At the time of operation there was gross evidence of tuberculous involvement of the posterior chest wall (Patient had a hematogenous form of tuberculosis and there had been involvement of the spine and lymph nodes). A thick placque of the posterior parietal pleura was removed, exposing some erosion of the ribs and abnormal appearing muscle. Four months after discharge the patient was readmitted. Several weeks later a large quantity of green colored purulent material was drained from the subscapular space. The most likely source of infection was the tuberculous involvement of the chest wall.

The one developing empyema had a difficult postoperative course after decortication and segmental resection of the apicoposterior segment of the left upper lobe. He had previously been treated with a left pneumothorax which resulted in thickened pleura, especially over the lower lobe. After a rather difficult decortication the lower lobe did not expand properly at the operating table. It was concluded that interstitial fibrosis was present. Although suction was applied to the intercostal drainage tubes in the operating room and continued in the patient's room, re-expansion of the remaining left lung was incomplete. Empyema developed from a bronchopleural fistula which required drainage. Finally, thoracoplasty was necessary to obliterate the dead space. As a result of this experience it was concluded that thoracoplasty is indicated in such cases immediately or at least within two to three weeks.

In two cases it was necessary to insert intercostal catheters after drainage tubes had been removed in order to remove air pockets and obtain complete re-expansion of the remaining lung.

## PREOPERATIVE AND POSTOPERATIVE CARE

Preoperative preparation of a patient who is to have a segmental resection is no different from that for lobectomy or pneumonectomy. Postoperatively the patient needs the same careful management as patients having major resections. It is absolutely necessary that the remaining pulmonary tissue be completely expanded without any significant residual air pockets. The exposed surface at the site of the segmental resection will not heal as rapidly or completely if dead space remains.

## FOLLOW-UP STUDIES

A surgical procedure is only as good as the results obtained. Good relationships with the patients in this series has made it possible to obtain annual follow-up reports from almost all of them (Table 3). The majority were working or attending school at the time of the last correspondence. Among the 12 followed for 30 months or more, only the patient with hematogenous tuberculosis was not employed constructively. All had negative bacteriological studies of sputum following surgery.

## SUMMARY

A surgeon operating on a lung should be able to perform any type of pulmonary resection-lobectomy, pneumonectomy, or segmental resection — depending upon the pathology present. A knowledge of the anatomy of the bronchopulmonary segments, including their bronchovascular variations, is essential to successful segmental resection technique. Segmental pulmonary resection is a valuable procedure in the treatment of bronchiectasis, tuberculosis, and lung abscess. It also can be used advantageously when the nature of the lesion is not clear even at operation. With careful attention to pre and postoperative care, complications should be minimal in number and extent. The value of segmental pulmonary resection is becoming more apparent to the discerning physician in the management of patients with small undiagnosed lesions.

The experience of a personal series of 15 patients having segmental pulmonary resections with follow-up results is presented.

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# Hysterosalpingography in the Treatment of Infertility in the Female

KANE ZELLE, M.D., SPRINGFIELD

EFFORTS to determine the patency of the fallopian tubes have been thought to have therapeutic value in the treatment of infertility but only recently has there been any notable accumulation of literature on this subject. The hysterosalpingograph in particular has been regarded as a diagnostic rather than a therapeutic measure. However, such investigators as the Weirs[11], Matters[4], and King and Herring[2] have reported marked success with this procedure. Though this discussion deals primarily with the salingograph as a treatment for infertility, we wish to point out that this method of therapy is not employed until simpler methods have been exhaustively explored.

When is the salpingograph to be used therapeutically? The following criteria are employed:

1. A healthy couple who have been trying to achieve pregnancy for two years.

2. The husband must have a sperm count of at least 60,000,000 with a majority of normal morphologic forms and good motility.

3. The woman's pelvis must be essentially normal. The preliminary work-up includes eradication of cervicitis and vaginitis and correction of retrodisplacement with a Smith-Hodge pessary. Routine Rubin tests are run in the office.

4. A normal ovulatory curve must be obtained by basal temperature charts, as this determines the time for salpingography, which is done prior to ovulation, usually on the ninth or tenth day day of the cycle. If anovulatory bleeding is suspected, endometrial biopsy is done on the first day of menstruation.

5. A positive Huhner test at the end of two hours is necessary.

6. We require a normal or corrected BMR or PBI. By a corrected basal rate, we mean the administration of thyroid to patients who show a deficiency. However, thyroid is given empirically to infertility patients with normal basal rates.

Since the primary contraindication to salpingography is the presence of pelvic inflammation, a white blood count and sedimentation rate are run, particularly if there is a history of PID or any evidence of residues such as thickening of the broad ligaments on pelvic examination.

The historical aspects of the introduction of radiopaque materials into the uterus and fallopian tubes for diagnostic and therapeutic purposes have been well documented, but improvement in the solutions employed and the equipment available for its instillation, has markedly decreased the hazards formerly encountered.

Rindfleisch[8] made the first attempt at uterine radiography in 1910, employing a bismuth emulsion. In 1914, Rubin[5] and Cary[1] used collargol® for this purpose. From 1922 to 1937 lipiodol was the most common medium. Rubin[6] in 1939 injected crystalloid organic iodides (rayopaque, diodrast, etc.) and these compounds have remained popular to the present time. The newest contrast media combine a water-soluble iodine compound with a vehicle which enchances viscosity. Many workers feel that oily media should now be regarded as obsolete.

All of the cases in the present study were injected with a solution of polyvinyl pyrrolidone to which has been added sodium acetrizoate.* This preparation has notable advantages, among which are its high tolerability with little or no pelvic irritability, rapid absorption (2 hours) which eliminates the danger of foreign body granuloma formation, and safety should accidental venous intravasation occur. This solution may safely be injected intravenously and is excreted by the kidneys. Since it may be employed at relatively low pressures with good results, the resultant discomfort is reduced and the time required is markedly decreased.

Also notable are advances in the equipment used to inject the solution. The present series

*Presented before Section on Obstetrics and Gynecology, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

*Salpix furnished by Ortho. Pharmaceutical Corp., Raritan, N. J.

of cases were done with a Weisman gynograph[12], an instrument that presents numerous advantages in both safety and maneuverability. Basically, the principle employed is the use of carbon dioxide, a nonirritating gas, under controlled pressure in a closed circuit. There is a flow meter for establishing a safe rate of gas flow, a diaphragm manometer for continuous observation of intrauterine pressures, and a pressure regulator to maintain constant pressure. A self-retaining canula which permits the free use of both of the operator's hands is a valuable adjunct. In this instance, a somewhat complicated apparatus greatly simplifies the operator's work.

The following technique is employed in obtaining the films. The patient is instructed to report to the hospital without breakfast early in the morning. Most of our salpingographs are done in the cystoscopy room in surgery because of the advantages of the cystoscopy table and the convenience of the X-ray apparatus. Should direct fluoroscopic control be desired, the procedure is carried out in the radiology department. Upon arrival at the hospital, the patient is given a hypodermic of morphine sulfate gr. 1/6 and scopalamine gr. 1/300, and placed in a recovery room to rest for 45 minutes. Preoperative medication is used to allay apprehension and because we feel that it plays a part in eliminating spasm, thereby reducing the pressure necessary for the radiopaque material to pass through the fallopian tubes.

The patient is then draped and the vaginal vault prepped with Merthiolate®, after which the cervix is painted with a solution of 20 per cent benzocaine* which greatly reduces the discomfort entailed when the cervix is grasped with a tenaculum and pressure exerted. As described above, the Weisman gynograph with a self-retaining canula is employed for injection of the medium. The rate of flow is set to a volume of 15 cc. of $CO^2$ per minute and the maximum pressure, to 200 mm. of mercury. Three cc. of radiopaque solution is injected through the gynograph and the first film is taken. This is usually enough to outline the uterus and at least the proximal portion of the fallopian tubes. While the first film is being developed, another three cc. is injected. The pressure may be increased to 220 mm. mercury if there is apparent obstruction. A second film is taken, the canula removed, and the patient returned to the recovery room to rest for an hour before discharge. No follow-up film is necessary with the employment of water-soluble media.

The procedure is accompanied by a feeling of lower abdominal fullness as the uterus fills, and some moderate cramping as the solution passes through the utero-tubal junction. In no case was discomfort great enough to cause us to discontinue the procedure. A slow and constant rate of flow minimizes the pain. Three patients reported cramping for about 24 hours postoperatively. None required further sedation other than the original preoperative medication.

The use of the new media, plus an apparatus which controls maximum pressure and rate of flow, obviates most of the danger formerly connected with this procedure. Marshak[3] and also Vogt[10] have demonstrated the safety of the hysterosalpingography. In the present series the only known complications were the pain reactions described above.

The present series of 20 private patients met the criteria already listed. They had failed to conceive after therapy employed in our routine infertility work-up. The results following salpingography were as shown below. Three patients had bilateral occlusion at the utero-tubal junction, which was not relieved at a maximum pressure of 220 mm. of mercury. Only one of these patients subsequently conceived. In the remaining 17 women there were nine pregnancies in which conception occurred within five cycles after hysterosalpingography.

The breakdown on the nine patients who conceived is as follows:

A. 2 of the patients never menstruated after salpingography
B. 1 conceived after one cycle
C. 3 after two cycles
D. 2 after three cycles
E. 1 after four cycles

Of the 9 patients who conceived, three showed only one patent fallopian tube on the salpingogram. In two cases, repeat salpingograms were necessary.

## CASE REPORTS

Mrs. J. B., a 30 year old gravida O who had been married for five years, had never employed any contraceptive measures. She gave a history of regular menstrual cycle with no abnormal-

*Americaine Topical furnished by Arnar Stone Laboratories, Mount Prospect, Ill.

ities. Her past history was negative, except for a childhood episode of jaundice and a possible malarial infection seven or eight years prior to her examination. The general physical examination was essentially negative, and the patient's pelvis was normal. Blood count and sedimentation rate were normal and her corrected BMR was plus 5 (she had been taking 1 gr. of thyroid daily for over two years.) Examination of the husband by a urologist revealed a sperm count of over 100,000,000, with essentially normal morphology and good motility. The Huhner test was strongly positive and $CO^2$ passed at low pressure with pain on Rubin. A hysterosalpingograph was done on 10/27/53. The patient's last normal menstrual period began on 10/15/53. She was delivered 7/30/54 of a normal healthy male infant after an uneventful pregnancy.

Mrs. R. B., was a 23 year old gravida 1, para 1, whose first pregnancy had terminated in a missed abortion following a severe hyperemesis gravidarium two years prior to her first visit. Routine fertility work-up showed no demonstrable cause for failure of conception. A salpingography on 11/2/53 showed occlusion at the utero-tubal junction and was accompanied by severe cramping pain. A second series of films on 5/24/54 showed the tubes filling to the distal end, but no radiopaque material in the peritoneal cavity. The patient's last normal menstrual period was 1/1/55. A third salpingography was done on 1/11/55. The patient has had no further menstrual bleeding and a frog test is positive. The uterus is enlarging and an apparently normal gestatory progression is occurring. The case illustrates the value of repeated salpingography in patients with apparent occlusion.

## DISCUSSION

It is felt that the presentation of even such a small series as this is justifiable because the basic approach is one of therapy rather than diagnosis. The patients selected for hysterosalpingography were those in whom no other cause for infertility could be determined. While the control of private patients is not rigid as would be possible in a group of clinic patients, we feel that the corrected BMR does not invalidate the results, as all of these women had been taking thyroid without conceiving for at least 12 months prior to salpingography.

Why these patients conceived after salpingography is difficult to say except for the factor of mechanical dilatation of the tubes just prior to ovulation. Weir and Weir[11] suggest a number of possibilities, among which are a stimulating effect on the tubal epithelium due to the iodine, increasing ciliary activity, a systemic action enhancing ovulation, or stimulation of the spermatozoa. They also mention the psycho-theraputic effect of the procedure, which those of us who are interested in the study of fertility will readily admit may become a vital factor. There is undoubtedly a psychosomatic basis for failure to conceive in many instances. This is a field in which there are great possibilities for further exploration.

We feel that in carefully selected cases who have met the criteria outlined above, hysterosalpingography is a valuable and safe adjunct to the routine treatment of infertility. Employment of the proper radiopaque media and apparatus for instillation make this procedure safe and relatively simple.

## SUMMARY

1. A series of 20 infertile females in whom examination revealed no cause for sterility were treated with hysterosalpingography, employing a water-soluble iodide compound. Nine, or 45 per cent, conceived within five cycles following treatment.

2. We believe that properly performed, this is a valid therapeutic method in the treatment of infertile patients who have been unable to conceive after thorough routine preliminary study.

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# Carcinoma of the Larynx: Classification and Results of Treatment

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THE introduction of the supervoltage machines and cobalt units a few years ago has been followed by a number of enthusiastic reports on their use in cancer of the larynx.[1] The period of observation has necessarily been rather short. As a basis for comparison it seems advisable at this stage to review the results of treatment under the well tried and more generally accepted methods such as surgery and the 200 and 250 KV deep X-ray machines.

## CLASSIFICATION

There is considerable confusion as to the clinical classification of tumors of the larynx. The accepted method in the past was to divide laryngeal tumors into subglottic, intrinsic, and extrinsic groups.[2,3] The subglottic group is clearly defined as tumors arising within the larynx between the lower border of the cricoid cartilage and the under surface of the true cord. When, however, we consider the intrinsic and extrinsic groups we are confronted with confusion. Some laryngologists consider intrinsic lesions to be those involving only the true cord[4]; others consider them to involve possibly the ventricle and the under surface of the false cord[5]; while some few accept lesions involving even the upper surface of the false cord[2]. The term extrinsic is applied to lesions arising anywhere above the indefinite superior limit of the intrinsic area and on the outer, or pharyngeal, surface of the larynx. As a result of this difference of opinion, it has been almost impossible to compare the results of different forms of treatment at various centers. The only series which has borne comparison are those of limited cordal lesions. This will be mentioned later.

The classification suggested in the First Report of the International Committee for Stage-Grouping in Cancer and for the Presentation of the Results of Treatment of Cancer (I. C. P.-R. )[6], is welcome and is shown in Table 1. This classification is similar to one used by some radiotherapists and by a few laryngologists in recent years.[7,8,9]

Table 1

Anatomical Sites of Carcinoma of the Larynx (I. C. P. R.)

| |
|---|
| Carcinoma of the Supraglottis |
| Carcinoma of the Glottis (vocal cords) |
| Carcinoma of the Subglottis |
| Carcinoma Occurring in Borderline Areas "Lesions which arise at or near the upper border of the larynx in which on examination it is impossible to state accurately whether the original lesion began within or without the larynx are considered to be pharyngeal carcinoma." |

## STAGING

The staging as well as classification has been of various types but the I. C. P. R. method, previously described by Leborgne[8], is the one used in this series and is shown in Table 2.

Table 2

Clinical Stages in Carcinoma of the Supraglottis Glottis and Subglottis (I. C. P. R.)

| | |
|---|---|
| Stage 1 | — Carcinoma limited to the mucous membrane. Full mobility of the larynx retained. No nodes palpable. |
| Stage II | — Carcinoma, infiltrating but not extending beyond larynx. Mobility of larynx impaired or lost. No nodes palpable. |
| Stage III | — Carcinoma extending beyond larynx, or nodes palpable but movable. |
| Stage IV | — Involvement of skin, or nodes fixed, or distant metastasis present. |

*From the Division of Otolaryngology of the University of Chicago*

*Presented before the Section on Eye, Ear, Nose, and Throat, 115th Annual Meeting of the Illinois State Medical Society, May 17, 1955.*

The term "mobility of the larynx" should be noted. The obvious meaning, mobility of the whole larynx on deglutition or palpation is certainly not intended nor does it mean movement of the vocal cords in all sites. In the supraglottic lesions it refers to the movement of the ventricular fold; in the glottic lesions, to movement of the vocal cord; and in the subglottic lesions it must refer to cord movement also. This latter is a weakness in the system but as this group is relatively small it is not very important.

Certainly this system of staging is an improvement on that previously accepted, the system of Nielsen[10] where the glottic lesions are adequately dealt with but the subglottic are arbitrarily allocated to stage III and supraglottic lesions to stage IV. Thus in the Nielsen staging, results of the treatment in stages I and II give higher results because the unfavorable noncordal cases are excluded and the survival rates in III and IV are raised by including the early noncordal lesions with the advanced cordal cases. If some such scheme of classification and staging, as suggested by I. C. P. R., were accepted internationally by both surgeons and radiotherapists, a more accurate presentation of results and comparison of results would be possible. Further, results of relatively small series would be of value, as they could be summated to give numbers which could be evaluated on a sound statistical basis.

## TREATMENT

*Surgery*: In this series the surgical treatment has consisted of:

1. Biopsy with apparent complete removal.
2. Laryngofissure.
3. Laryngectomy.
4. Radical neck dissection for metastatic nodes.

Endoscopic removal was performed only once and gave over five years of freedom before recurrence. Laryngofissure was the other conservative surgical procedure. There were no hemilaryngectomies or other modifications. In no case was a radical neck dissection performed prophylactically and only one patient had a bilateral neck dissection. The surgery was performed mainly by Drs. Lindsay, Perlman, Schuknecht, and Brunschwig.

*Radiation*:

1. Deep X-ray.
2. Neck pack (1 case).

No cases were treated by the Finzi Harmer fenestration technique, endoscopic needling, or interstitial deep X-ray of Lambert and Watson techniques. Recurrences were treated by laryngectomy. Treatment was carried out under the direction of Dr. Carpender and Dr. Hamann. So far there is little evidence that supervoltage machines or cobalt units will replace the standard 200, 250, or 500 KV X-ray machines in the curative radiotherapy of superficial tumors such as of the larynx; or, if they do, the results will be no better as cancer lethal doses are readily achieved by the older methods. Reduced skin dosage and reaction are the only major advantages of the newer machines.

*Results*: The cases under review are a series seen in the University of Chicago Clinics up to December 31, 1949. These patients have been observed, if alive, for at least five years. Not included in the series are cases which have been partially treated at other centers and those where death has occurred from other causes. Patients who have failed to return for examination or those we have failed to contact have been counted as failures, as it is assumed they have died from the malignant lesion. This does not improve the five year survival rate. The series consists of 47 cases of which a summary is presented in Table 3.

Table 3
47 Cases under Treatment by Surgery, Radiation, or Combination

| Classification | No. | 5 Year Survival | % |
|---|---|---|---|
| Supraglottic | 11 | 6 | 54.5 |
| Glottic | 36 | 28 | 77.7 |

The number of cases in this series is considered too small to give an accurate evaluation of treatment particularly when broken down into various sites and stages, but some observations can be made.

Of 11 supraglottic cases, six (54.5 per cent) gained five year survival.

Of 36 glottic cases, 28 (77.7 per cent) gained five year survival.

There were no cases in the subglottic group.

These overall figures confirm the well established fact that the prognosis of the glottic group is much better than that of the supraglottic.

The glottic lesions have been broken down into stages in Table 4.

Table 4
Glottic Cancer

| Stages | No. | 5 year Survival | % |
|---|---|---|---|
| I | 9 | 9 | 100 |
| II | 25 | 18 | 72 |
| III | 1 | 0 | 0 |
| IV | 1 | 1 | 100 |

The excellent results in stage I glottic cancer are apparent. Of nine cases, nine gained five year survival.

Of 25 cases in stage II, 18 (72 per cent) attained five year survival.

There was only one case in each of stages III and IV and these, therefore, will not be studied further.

It is to be noted that 70 per cent of cases in this glottic group were in stage II.

In Table 5 the nine cases in stage I have been broken down according to the treatment received.

Table 5
Glottic Stage I

| Treatment | No. | 5 Year Survival |
|---|---|---|
| Surgery | 3 | 3 |
| Radiation | 6 | 6 |
| Combined | 1 | 1 |
| All cases to Surgery | 4 | 4 |

One patient treated by radiation had a recurrence at the end of 6½ years and was then treated by laryngectomy. He is alive and well 11½ years after diagnosis.

On reviewing the results of treatment of the limited or stage I glottic lesion by surgery and radiation at 11 centers throughout the world it was noted that there was considerable variation in the results obtained by both types of treatment. [5, 11, 12, 13, 14, 15, 16, 17, 18, 19, 9]

The difference in surgical results may be mainly due to selection of cases. Some surgeons may be particularly careful to do the conservative operation only on well localized unilateral lesions while others will tend to be more optimistic. Likewise with radiation there is considerable variation which may be due to differences in experiences and technique.

If we compare the average results of surgery with the average results of radiation therapy at these various centers we find that there was a difference of only two per cent in favor of surgery: 88 per cent as compared to 86 per cent having gained a five year survival.

In Table 6 the glottic stage II lesions have been broken down according to the treatment received surgery, deep X-ray, or combined therapy.

Table 6
Glottic Stage II

| Treatment | No. | 5 Year Survival | % |
|---|---|---|---|
| Surgery | 11 | 8 | 72 |
| Radiation | 14 | 6 | 43* |
| Combined | 10 | 7 | 70 |
| All cases coming to surgery | 20 | 14 | 70 |

*Two cases subsequently required laryngectomy thereby reducing the long term survival rate to 28.5 per cent.

Of the 11 cases undergoing laryngectomy, eight (72 per cent) obtained five year survival. In this series, one patient had a localized lesion of one cord which had caused reduced movement of the cord. Endoscopic removal gave over five years of freedom from recurrence. A further period of five years has been gained by radiotherapy.

If the 14 cases receiving primary radiotherapy are examined in detail, we find five-year survivals in six patients. Two of these subsequently required laryngectomy and are alive and well at 10 and 16 years postoperatively. While the five year survival rate was 43 per cent, the long term cure rate was 28.5 per cent in the cases receiving radiation only. Of the nine cases later subjected to laryngectomy six gained five year survival following surgery. So, of the 14 cases receiving primary radiation no less than 10 (71 per cent) eventually gained five year survival. It should be pointed out that the Group II cases which were radiated were mainly a selected group in what may be called early Stage II. Cases in late Stage II were recommended for primary laryngectomy.

Of the 10 cases which received one form of treatment followed by the other, when the tumor failed to respond or where there was recurrence after months or years, seven (70 per cent) gained five year survival after the second form of treatment. If we examine all cases coming to surgery

we find that of 20, 14 (70 per cent) gained five year survival which was approximately the same as that obtained in those receiving only surgery.

From this experience, again remembering that it is only a small series, in early cases of stage II, when there is doubt as to choice of treatment between radiation and laryngectomy, or when it is imperative to save the voice, even though radiation does not give as good results as surgery in stage II, it is fairly safe to give radiation first and treat by surgery later if there is recurrence. The percentage of five year survivals after delayed laryngectomy appeared to be as good as if surgery had been undertaken in the first instance and in addition, the patients retained the voice. However, the responsibility of the laryngologist is greatly increased since it is up to him to discover recurrence at the earliest possible date. For this reason, patients receiving this treatment must report frequently and direct laryngoscopy and biopsy must be undertaken on the slightest suspicion.

The I.C.P.R. method of classification also has been used in recent reports by Lederman[9] and Scharer[20]. Treatment of glottic carcinoma, stage II, by radiation therapy by these authors gave five year cures in 35 and 53 per cent respectively. By comparison, the results obtained in our series were 43 per cent by radiation and 70 per cent by surgery of five year cures.

Of the 11 supraglottic cases, one was in stage I, four were in stage II, six in stage III, and none in stage IV. The overall five year survival percentage was 45. It is significant that 54 per cent of cases were in stage III (Table 7) as compared with 70 per cent in stage II in the glottic group (Table 4).

Table 7
Supraglottic

| | No. | 5 Year Survival |
|---|---|---|
| Stage I | 1 | 0 |
| Stage II | 4 | 1 |
| Stage III | 6 | 4 |

The treatment used in the supraglottic cases is shown in Table 8.

Of nine cases treated primarily by radiation, only two gained a five year survival. However, this group includes some cases considered to be inoperable. The two cases undergoing laryngectomy primarily gained five year survival and of three having surgery following radiation two were five year survivals. Due to the small number of cases in this group it is impossible to examine the results of the two forms of treatment, in the various stages.

Table 8
Supraglottic

| | No. | 5 Year Survival |
|---|---|---|
| Radiation | 9 | 2 |
| Surgery | 2 | 2 |
| Combined | 3 | 2 |
| All coming to surgery | 5 | 4 |

While remembering that some of the radiation cases may have been receiving only palliative treatment the impression is gained that surgery offers more than radiation in this group, with the help of antibiotics and improved techniques in neck surgery.

## SUMMARY

The results attained at the University of Chicago Clinics along with those reported from other centers on the treatment of carcinoma of the larynx seem to warrant several conclusions. In stage I glottic lesions, excellent results can be obtained by either radiation or surgery.

Where the quality of the voice is an important consideration, radiation offers some advantage over surgery. Provided that radiation is properly controlled and a careful follow-up is possible to detect recurrence, the use of radiation seems justified in such cases. The radiation treatment used in this series was deep X-ray with the 200 KV machine.

In stage II glottic carcinoma, the results of surgery were better than those by radiation. However, as indicated there is a small group in the borderline between stages I and II where radiation may be safely tried and surgery reserved for recurrence.

For some time, at the University of Chicago Clinics, cases that have passed from Stage I into borderline or early stage II where the choice of treatment lies between radiation and laryngectomy and no longer between radiation and fissure or some other conservative surgical procedure, radiation has been carried out and any recurrence treated by laryngectomy. When there was recurrence, laryngectomy has given almost as good five year survival rates as cases treated primarily by surgery. This policy has had the advantage of

allowing a certain percentage of patients to retain the voice.

In the supraglottic tumor, the impression gained from this series is that surgery offers a better five year survival rate than does radiation.


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## The course of hypertension

Ever since the time of Volhard and Fahr it has been recognized that essential hypertension behaves in two contrasting ways. In the first, or benign course the condition is stable for long periods and when death comes it is due to heart failure in about half, to cerebral vascular disease in about a fifth, and to intercurrent disease in the remainder. In the second, or malignant course — distinguished clinically by what used to be called albuminuric retenitis and what is now commonly termed hypertensive neuroretinopathy — the course is rapidly progressive to death from renal failure within a year. I have long between persuaded that the differences between the benign and malignant courses are chiefly consequences of differences in the intensity of hypertension. First, it is general experience that, on the whole, patients with malignant hypertension tend to have higher pressures. There are two qualifications — namely, that patients with a recent hypertension, such as with pregnancy toxemia or acute nephritis, may enter the malignant phase at a lower pressure than those with prolonged hypertension, and that both the retinal lesions and fibrinoid necrosis may be found in disseminated lupus and polyarteritis nodosa at normal pressures. Second, the malignant phase may occur in any form of hypertension, e.g., pyelonephritis or Cushing's syndrome, provided it is sufficiently severe. Third, there is now overwhelming evidence that the malignant phase may be reversed to the benign phase by any therapeutic measure that reduces the arterial pressure sufficiently for sufficiently long. This is true whether the malignant phase be engrafted on essential hypertension, pyelonephritis, Cushing's syndrome, or other malady, and whether the remedy be pyrogens, salt poor diet, sympathectomy, adrenalectomy, or nephrectomy, or the use of the new numerous hypotensive drugs. *G. W. Pickering, M.D. The Concept of Essential Hypertension. Ann. Int. Med. Dec.* 1955.

# Common Genito-Urinary Tract Problems In Children

I. Keith Neece, M.D., Decatur

THE reason for presenting this paper is that urologic problems in children are one of the most easily missed entities in the practice of medicine. This applies not only to the general practitioner and pediatrician but to the urologist. For the purpose of simplicity, these conditions may be grouped as follows:

1. Congenital anomalies, including obstructive uropathies.
2. Infections.
3. Neoplasms.
4. Injuries and accidents.

The symptom complex in the young manifested by any or all of these disorders may simulate gastrointestinal tract pathology and even central nervous system disease. However, the cardinal symptoms are pyuria, hematuria, and pain.

Congenital anomalies most commonly found are hydroureter and hydronephrosis due to valvular or vascular aberrancies. Valvular anomalies of the bladder neck are common. Figures 1 and 2 show a combination of all of these in a newborn. You can see the reflux up the massively dilated left ureter ending in a marked calicectatic renal pelvis with practically no parenchymal margin showing. Also in the film can be visualized a voiding cystourethrogram showing the valvular defect at the vesical neck and in the urethra. Reduplication of the ureters and renal pelves is common with or without extra-vesical ureteral opening.

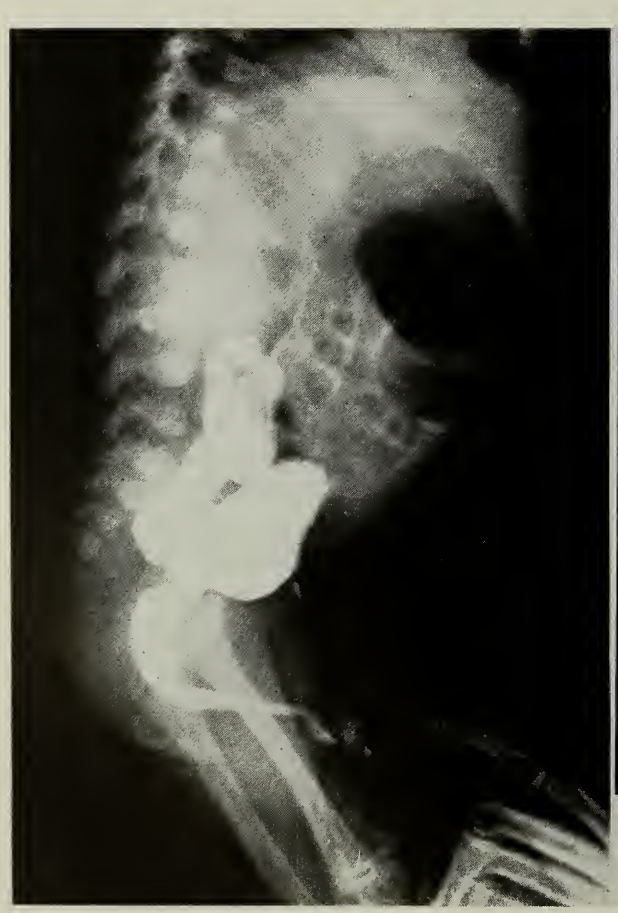


Figure 1

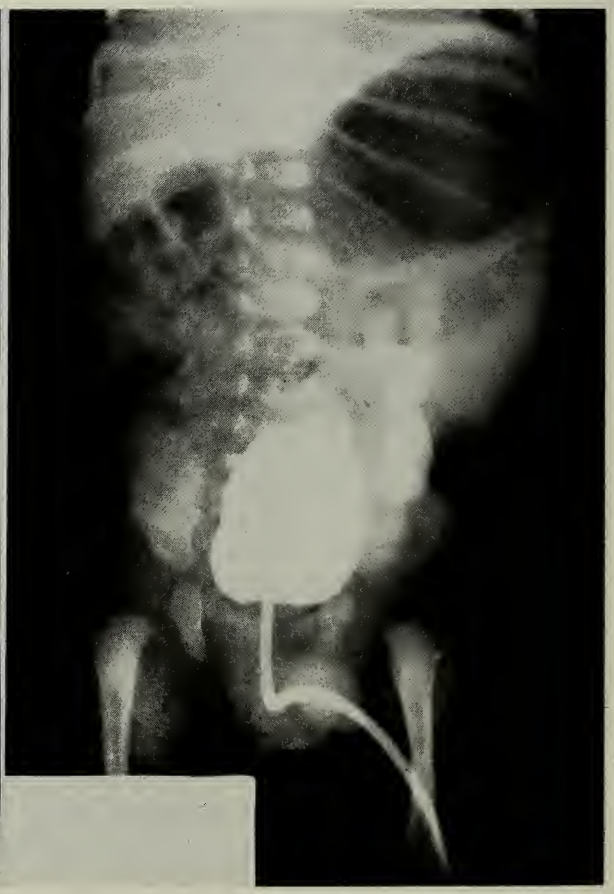


Figure 2



Figure 3



Figure 4

In Figure 3 you can readily see the greatly dilated reduplicated ureter opening into the urethra of a female child. The true renal pelvis on the right side is visualized beneath the reduplicated dilated ureter at this point; the ureter from this segment emptied from a normal orifice on the trigone within the bladder. This 16 month old child was brought in because of a severe, resistant pyuria, chills, and fever. Correction of her difficulty required heminephrectomy and ureterectomy.

Calycine diverticulum is another of the common causes of recurrent pyuria and most cases come to surgery in later life because of concomitant calculus disease. One particular child has been having recurrent bouts of pyuria and had not progressed well in growth, since she was 8 months old. Our retrograde pyelograms showed a calycine diverticulum. This filling persisted after an interval of one hour, nicely exhibiting the tendency toward stasis and puddling.

Solitary cystic disease of the kidney is another Embryologic accident, this one being picked up on a routine physical examination by an alert pediatrician. Surgery revealed only a large solitary cyst with a fibrinous band representing the primordial ureter (Figure 4). This is a film taken at the operating table after injection of 20% skiodan into the cyst cavity. The child went through surgery and set a record in going home on the fourth postoperative day and is now well.

The etiologic agents most common in lower urinary tract infections in infants and children are the coliform group of organisms. Further, the usual staphylococcus and streptococcus groups also are frequent offenders. The most difficult organisms to handle are B. proteus and B. aerogenes and are best treated by relying upon repeated antibiotic sensitivity tests for the drug of choice. The importance of sterile technique in obtaining catheterized urines cannot be overemphasized as voided specimens are uniformly unreliable and misleading.

A worrisome dermatitis, so far as parents are concerned, is caused by the ammonia splitting group causing so-called diaper rash, with secondary monilial invaders. This can lead to ulceration and meatal inflammation in the male and

severe direct extension of urethritis in the female. Usually the commercial preparation, Diaperene®, for diaper rinse and the use of ointment or powder will suffice to clear up this type of infection and keep it clear.

In the experience of our group, the most commonly overlooked entity in the production of vaginitis and urethritis in the female is an adherent clitoris with coaptation of its labial-preputial fold. There is an accumulation of smegmatic material beneath this structure and often sebaceous cyst formation. This encourages infection of the vulva, vaginal tract, and urethra, which usually is long standing with recurrent bouts of urethrocystitis and enuresis. Most cases respond to simple clitorodotomy with wedging out the labial prepuce and approximation of skin and mucous membrane primarily. Follow-up instruction of the child's mother in proper vulval hygiene is mandatory because even the so-called intelligent mother seems to have an aversion to adequate cleansing of their female offspring's genitalia.

Genitourinary tract neoplasms have uniformly a bad prognostic outlook when they occur in children. Practically all of them are embryonal in origin of the Wilms's type with characteristics of fast growth within the capsule until late in the process when break-through occurs with attendant hematuria. This is often the first sign of trouble and the process is far advanced. One 5 year old boy had symptoms of intermittent, painless hematuria for two months. He had an adequate urologic workup wherein a diagnosis of neoplasm of the right kidney was established and he was operated. In spite of a radical nephrectomy he died in nine months with generalized metatases. Other tumors of the retroperitoneal area have a better prognosis as they usually are lipoma, myxoma, fibroma, or hamartoma. Least common are the lymphatic tumor series (lymphoma and lymphosarcoma) with their associated poor prognoses due to involvement of other systems. Tumors of the ureter, bladder, and urethra are uncommon.

Finally, the general practitioner must always be alert to the more bizarre problems presented, because while they constitute "urologic oddities" they are common. Children, being children, with their inherent curiosity about each other have supplanted behind the barn activities to the base-



Figure 5

ment in today's urban life. Thus, any pyuria, hematuria, vaginitis, or genital irritation should be screened for foreign bodies. Figure 5 shows a massive vesical calculus which was picked up because the young man had had typical symptoms of pyelocystitis. Symptoms had been recurring at intervals since the age of 9 or 10. On this admission, his temperature was 105.4 degrees F. and he was a sick lad. In the past his difficulty had been variously diagnosed as flu, pyelitis, and bacillary dysentery until his last attending man ran a KUB film and a careful urine which revealed 4+ pus and blood.

After a suitable period of therapy, aimed at overcoming the severe systemic infection caused by this calculus, the stone was removed. One of my associates, upon cutting open the specimen was not too surprised to find a wooden stick which had acted as a nucleus. The patient made an uneventful recovery and upon questioning could not recall how that stick had made its way into his bladder. How much easier it would have been years before to have had a simple screening X-ray to aid in diagnosis and the institution of adequate therapy. Sundry other agents have been retrieved from the vaginal tract and urinary bladder including bobby pins, roller skate keys, crayons, and chewing gum. In passing, I might say that vaginoscopy can be carried out easily and without trauma with a McCarthy panendoscope in the smallest infant.

Routine diagnostic measures available to the general practitioner as an office procedure can be easily carried out: catheterization in all cases for urethral obstruction and residual urine; careful examination of the clitoris and prepuce and inspection for signs of vaginitis in girls. If there is anything positive forthcoming, further study

should be carried out in the hospital, including excretory urograms; cystograms, including delayed films or reflux; and cystoscopy and retrograde pyelography.

**SUMMARY**

Any infant or child with unexplained fever, pyuria, or hematuria should have a screening genitourinary tract survey. Congenital anomalies are most common and, if picked up early enough, will allow reconstructive plastic procedures with resultant salvage of renal substance instead of nephrectomy at a later date. The easily overlooked problem of an adherent clitoris in girls is re-emphasized and a simple corrective measure is brought to your attention. With recent improvements in our diagnostic and surgical armamentarium directed toward the urinary tract, we can now alleviate much suffering and salvage many children if careful studies and corrective techniques are carried out early in the disease.

« « «  » » »

# Anesthetic Management of the Poor Risk Patient Undergoing Transurethral Prostatic Resection

**Constance L. Graves, M.D., and Mary Karp, M.D., Chicago**

WHILE we propose to discuss the way our department manages the poor risk patient undergoing a transurethral prostatic resection, that method does not vary from our management of the routine case. Or one may invert the statement and say that since the majority of the patients undergoing transurethral resection are poor risk, our management of the routine case is the same as our management of the bad one. At any rate our clinical sense of satisfaction with our method of management has been more or less substantiated by a long range survey of results.

In this series of nearly 1,200 patients undergoing transurethral prostatic resection over a 10 year period at the Chicago Wesley Memorial Hospital, 59 per cent were found to be in a risk classification other than I, and 68 per cent of these patients were past age 60. Approximately 40 per cent had some form of heart or cardiovascular disease while 50 per cent had some other moderate to severe systemic disease. Almost no disease was unrepresented in the roster of pathology and yet almost no disease constituted a contraindication to the operation.

A transurethral prostatic resection presents a number of interesting problems to the anesthesiologist. There is the question of the proper choice of anesthetic agent for any patient undergoing the procedure, and there is the special problem of the poor risk patient. In addition, most of the patients who come to the operating room for a prostatic resection are elderly, so that anesthetic management of these patients is likely to become a problem in geriatric anesthesia regardless of the risk.

Old age per se does not increase the risk in surgery. The aged usually are in a risk classification other than I because of the presence of some disease state. Most people who survive to old age do so because of a sturdy constitution and hence can be expected to withstand a great deal. Nonetheless, geriatric anesthetic has a few problems of its own.

*From the Department of Anesthesiology, Chicago Wesley Memorial Hospital, and Department of Surgery, Northwestern University Medical School, Chicago, Illinois.*

*Presented before the Section on Anesthesiology, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

## CHOICE OF ANESTHETIC AGENT AND METHOD

Over a period of years our departments of anesthesiology and of urological surgery have come to the conclusion that spinal analgesia is the anesthetic method of choice for all patients undergoing transurethral prostatic resection, and we feel it is the safest anesthetic to use for all types of risks with but few exceptions. Actually, for the procedure under discussion, regardless of the risk or age of the patient involved, the choice of anesthetic is limited to the nonflammable ones. Thus, for practical purposes, we are confined to one of three possibilities: (1) spinal analgesia, (2) caudal analgesia, and (3) intravenous anesthesia.

Caudal analgesia is time-consuming, uncertain in its results, and requires a large volume of drug to reach the anesthetic level satisfactory for transurethral resection. For these reasons we use caudal analgesia only when spinal or intravenous anesthesia is undesirable for some reason.

Intravenous anesthesia has its advocates but it presents many disadvantages. It is not desirable in patients suffering from some respiratory or cardiac diseases. The average duration of our cases is over 60 minutes, so that uncomfortably large doses may be required, and we feel that this should be avoided in older patients. There may be a long emergence period, particularly in the elderly patient, leading to the danger of asphyxia, atelectasis, or pneumonia. Some of these patients, having lost contact with reality through loss of consciousness, tend to remain disoriented for long period of time.

Spinal analgesia has few contraindications, and we feel that its advantages, convenience, and relative safety make it the anesthetic method of choice for this operation. The few situations in which we do not unhesitatingly use spinals are: (1) pre-existing disease of the central nervous system such as central nervous system syphilis and pernicious anemia; (2) severe arthritis or spinal fusions where a lumbar puncture may be technically difficult (but which we usually try anyway); and (3) a repeat resection which is expected to be a short procedure. It should be pointed out, however, that in the series of cases previously mentioned almost as many repeat resections were done with a second spinal as with an intravenous anesthetic; and we feel that there is no reason to hesitate to give a second spinal.

For the past 12 to 14 years we have used spinal analgesia routinely for transurethral prostatic resections unless there was some special contraindication. In the series reviewed, about 80 per cent of the cases were done with low spinal anesthesia. Since our management of all patients is fairly standard, we shall discuss our routine management.

## ANESTHESIA TECHNIQUES

The lumbar puncture is done at the most convenient interspace, usually between the third and fourth lumbar spines. Novocaine 1 per cent is used along with ephedrine sulfate, 50 mg. for the skin wheal; the vasopressor helps circumvent postspinal hypotension. The anesthetic agent used is pontocaine hydrochloride 1 per cent diluted and weighted with dextrose 10 per cent so that the final anesthetic percentage is between 0.4 per cent and 0.5 per cent pontocaine. We rinse the syringe prior to mixing agents with epinephrine 1:1000 to prolong duration of analgesia somewhat. The usual dose of ponticaine is 10 mg. although this may be increased or decreased for special circumstances. Following injection of the drug intrathecally, the patient is turned into the supine position without the use of Trendelenberg. In most cases anesthesia develops to the tenth thoracic dermatome.

## COROLLARY MEASURES

Corollary measures used vary individually. We do not routinely use intravenous fluids during the operation. With a hypertensive patient or one whose cardiac status is poor, we may start an intravenous infusion merely to have a handy channel available in case vasopressors are necessary. In all other cases, intravenous fluids are started postoperatively when the patient is returned to his room.

Blood is given only as required. We do not feel that blood replacement is necessary in every transurethral resection. The number of our resection patients in the past 10 years receiving any blood is about one in 18. This figure includes all those receiving it postoperatively as well as during the operation.

Supplementary narcosis is almost never used. The patients are well sedated ahead of time with a barbiturate as well as with a narcotic, and most of them drowse through the procedure hard-

ly aware they are being worked on. In unusually nervous or apprehensive patients we may give a short-acting barbiturate intravenously. This is seldom done in the poor risk patient.

Complications arise and their management varies. Hypotension immediately after the spinal occurs in about 8 per cent of the cases. With these patients, an intravenous vasopressor restores equilibrium and almost never is a second dose required. Postoperative hypotension occurs occasionally and is treated with fluids, blood, or vasopressors as the situation requires.

Hypertension on the operating table is a surprising complication and is usually due to absorption of irrigating fluid from the open vascular bed at the operative site. When it occurs, we request the surgeon to restrict irrigating fluids or curtail the procedure. When absorption is severe enough to produce pulmonary edema, that is treated in the classical manner with intravenous aminophylline and oxygen under pressure.

We were at one time interested in postoperative nausea and vomiting, having found it to some degree in about half of patients undergoing transurethral resection and apparently having no particular relationship to the type of anesthesia employed. For a short time we used chlorpromazine pre- and post-operatively in all patients having a resection. We found, however, that the cure was worse than the disease as all these patients had a prolonged and completely refractory hypotension that lasted until the spinal wore off.

The mortality rate of the series was 1.3 per cent, taking into consideration all patients who died from any cause in the same hospital stay in which they had the resection. If all cases are excluded that could not be considered either operative or anesthetic deaths (as, for example, patients dying of generalized carcinoma or vegetative endocarditis), the figure would be less than 1 per cent. This compares favorably with figures reported from other institutions, ranging from 0.8 to 4 per cent.


**SUMMARY**

Because of our encouragingly small mortality rate and the absence of serious complications, we feel that our method of handling the poor risk as well as the routine patient undergoing transurethral prostatic resection has proved satisfactory, both clinically and statistically.



250 E. Superior St.


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## Diverticulitis

When an operation is considered necessary for diverticulitis, the ultimate objective should be to rid the patient of the offending segment of sigmoid colon. This means, for example, that if laparotomy has to be carried out for acute obstruction, resection is planned as the final objective, and transverse colostomy should be carried out in the proper position to allow for resection at a later date. If the patient is operated on for acute obstruction, a transverse colostomy similarly is indicated. It means that an operation such as drainage of an abscess due to diverticulitis is not in itself a proper operation; it not only is dangerous in itself but since it does not divert the fecal current, it makes no preparation for the final cure of the patient. Such operations as cecostomy are not advisable because they do not divert the fecal stream completely and cannot remain effective over the period of time that often is necessary between stages in a patient with diverticulitis. *Claude E. Welch, M.D. The Problem of Diverticulitis. California Med. Dec.* 1955.

# CASE REPORTS



# Adams-Stokes Syndrome and Gall Bladder Disease

**Irving Rudman, M.D., Frankfort**

IT IS NOW generally accepted that gall bladder disease may adversely affect pre-existing heart disease, especially in the aged. More recently, it has been suggested that the precipitation of syncopal attacks in patients with AV heart block may be brought on by stimuli arising from a diseased gall bladder[1]. There exists considerable evidence to support the view that transient syncope of Adams-Stokes syndrome is not provoked, each time, by a new injury to the cardiac conduction system. A neurogenic "trigger" mechanism is considered to be a logical alternative explanation, and the diseased gall bladder has been cited as a likely source of excitatory impulses in some cases.

A case history is presented in the belief that it provides clinical evidence to support the argument that gall bladder disease may provoke attacks of Adams-Stokes syncope.

The patient, an 84 year old white female, complained of a painful tender mass in the abdomen, of one week's duration. The mass, located in the right upper quadrant, was associated with pain, fever and nausea. She had had a cholecystostomy 15 years ago. In recent years, there had been a recurrence of upper abdominal distress after meals. These digestive symptoms had been obscured, however, by the frequent occurrence of syncopal attacks in the past four years. The spells were characterized by brief periods of unconsciousness that simulated sudden death. The patient had been treated empirically for long periods with Dilantin®, Dramamine®, ephedrine and phenobarbital without effect on the frequency of the episodes which were occurring as often as every two weeks at the time of the present illness. There were no symptoms of cardiac insufficiency. The patient was known to have had bradycardia for several years.

Physical examination revealed an elderly asthenic white female. The blood pressure was 200/50. The apical pulse was 20 with a regular rhythm. There was a globular, firm, tender mass in the right upper quadrant of the abdomen. There were no physical signs of cardiac decompensation. The electrocardiogram revealed complete heart block as well as evidence of diffuse ischemic changes in the myocardium. The auricular rate was 86. The ventricular rate was 16.

The patient was operated on with a preoperative diagnosis of hydrops of the gall blad-

*From the Hedges Clinic, Frankfort, Illinois*

der. During anesthesia induction, the pulse rate ranged between 16 and 20. An inflamed hydrops was identified. It was deemed advisable to keep operating time at an absolute minimum. Hence a cholecystostomy was performed with removal of several stones. Following surgery, the patient's pulse rate stabilized at 45. On the third postoperative day, an electrocardiogram revealed an auricular rate of 67 and a ventricular rate of 37. Recovery was rapid and uncomplicated. The cholecystostomy tube was removed on the eight postoperative day and bile drainage from the tract ceased 14 days later.

The patient lived 16 months following surgery. At no time during this period did she manifest symptoms suggestive of Adams-Stokes syncope. The patient was given ephedrine and phenobarbital regularly but, as mentioned above, this medication had failed to prevent increasingly frequent attacks preoperatively. Death occurred following the development of worsening bradycardia over a period of five days, culminating in cardiac standstill.


**SUMMARY**

A case has been presented of Adams-Stokes syncope with complete remission for 16 months following cholecystostomy and removal of gall stones.



REFERENCES

1. McLemore and Levine: Am. J. Med. Sc. 229:386-391, [April] 1955.



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## No oil for the aged

The problem of lipoid pneumonia in adults, especially in the older age groups, is more common than has been realized. The recent work of Volk and his associates discloses an incidence of 14.6 per cent in a series of 389 chronically ill patients. Our own series of cases represents an incidence of 2.5 per cent of necropsies. Our material would indicate that age, chronic illness, and diseases of the nervous system are prominent etiologic factors. It is apparent that these are the very factors which are likely to be associated with chronic constipation and the use of mineral oil as a cathartic. General inactivity would appear to be important when one considers the predominance of strokes and paralysis agitans in our material. One wonders if inactivity of the bowel and possibly of the cough reflex is not a more important consideration. On reflection, some factors related to the pathogenesis of lipoid pneumonia may be surmised. The role of swallowing difficulties is obvious, particularly if the patient is recumbent. In several of our cases this difficulty was not present. One can visualize the fate of mineral oil taken at bedtime. Lighter than gastric and abdominal contents, it tends to float uppermost in the stomach. The average pressure within the abdomen is positive and in the thorax is negative. The result is that globules of mineral oil may be sucked up into the esophagus. Oily substances tend to nullify ciliary activity. Since they do not have the ability to excite the cough reflex, it is easy to understand how they might be inhaled by the sleeping patient. Once in the lung, the relatively mild reactions noted on microscopy can be well understood. Once phagocytosed, some or all of the oil may be coughed up and phagocytes may spread the oil to other areas of the lung. In many areas the expulsive forces may be inadequate. *Herbert W. Greenidge, R.C.A.M.C. and Morley J. Tuttle, M.D. Lipoid Pneumonia in a Veterans Hospital. Ann. Int. Med. Dec.* 1955.

# EDITORIALS

## The 1956 Annual Meeting

The 1956 Annual Meeting of the Illinois State Medical Society will be held at the Hotel Sherman, Chicago, May 15-18, 1956. The preliminary program is published in this issue of the Illinois Medical Journal and the official program will appear in the May issue. Plans are well under way to make this a fine meeting, with a fine program, and the usual large number of technical and scientific exhibits.

The first meeting of the House of Delegates will be held at 9.00 a.m., Tuesday, May 15. The second meeting is scheduled for 3.00 p.m., Thursday, May 17, and the last session on Friday morning, May 18, at 8.30. The reference committee hearings will be scheduled for Wednesday and any member of the I.S.M.S. as well as the regularly elected component society delegates, may appear before any of these committees to discuss any report, resolution or other matters referred to the committees.

The Annual Dinner as usual, will be on Wednesday evening, May 16, and the after dinner speaker will be Elmer Hess, President of the American Medical Association, who will be a guest of the Society for at least two days during the annual meeting. The Public Relations Dinner meeting is scheduled for Tuesday evening, at 6.00 p.m. and the program will be of general interest not only to the P.R. committee chairmen of the component societies, but also to all members of the Society. The Council has ruled that because of the general interest, the charge for the dinner will be only one half of the cost to the society per plate.

The newly selected Public Relations Director, Mr. Edward A. Uzemack will be present and will be introduced to the audience at that time. Dr. Percy E. Hopkins, as Chairman of the Committee on Medical Service and Public Relations, will preside at this interesting function. Beginning at 9.00 p.m. on Tuesday, the Woman's Auxiliary will have a special entertainment in the Bal Taberin, sixth floor of the Sherman, to entertain the members of the Society. Although the program has not been announced, we are informed that it will be of interest to all members of the Society, and some surprises may be expected. There will be quite a number of invited guests from other states, who will appear on the General Assembly programs. The list is as follows;

Chester H. Warfield, Director, Department of Radiology, St. Joseph's Hospital, Consultant in Radiology, Veterans Hospital, Ft. Wayne, Ind.

John C. Ullery, Professor and Chairman, Obstetrics and Gynecology, Ohio State University, Columbus, Ohio

Harvey C. Slocum, Colonel, USA MC, Chief Consultant Anesthesia, Surgeon General; Chief of Anesthesia and Operating Section of Walter Reed Army Hospital

E. Grey Dimond, Professor of Medicine and Head of Department of Medicine, University of Kansas City, Kansas.

Robert Goode, Director of Pediatric Research, University of Minnesota, Minneapolis, Minn.

Henry P. Wagener, Rochester, Minnesota — Guest of the Section on EENT

Orator in Surgery: Brown M. Dobyns, Professor of Experimental Surgery, Western Reserve University School of Medicine, Cleveland, Ohio

Orator in Medicine: Charles H. Rammelkamp, Professor of Medicine and Public Health, Western Reserve University School of Medicine, Cleveland, Ohio.

Sergeant Elmer C. Paul, Supervisor of Auto Crash Injury Research Section, Indiana State Police, Indianapolis, Indiana.

Professor James A. Reyniers, Research Professor of Bacteriology, Lobound Institute, University of Notre Dame, South Bend, Indiana.

Charles G. Johnston, Professor and Chairman of Department of Surgery, Wayne University School of Medicine, Detroit, Michigan.

John H. Lamb, Clinical Professor of Dermatology, University of Oklahoma, Oklahoma City.

Vincent Derbes, Professor of Medicine, Tulane University; Visiting Physician, Charity Hospital of Louisiana, New Orleans, Louisiana.

Edward Krumbiegel, Health Commissioner of Milwaukee, Professor and Chairman Department of Public Health & Preventive Medicine, Marquette University, Milwaukee, Wisconsin.

Those responsible for the development of the fine programs, as well as officers and members of the Council hope that all members of the State Medical Society will make every effort to attend this meeting.

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**Correction please**

The omission of one line of type detracted from the value of the article "Medical Ethics" by Willard W. Fullerton, M.D., which appeared in our Medical Economics Section in February.

The complete final paragraph should read as follows:

It is now suggested that we each and everyone of us pledge, regardless of our station in the medical picture (specialist, general practitioner, educator, professor) to accept the responsibility of treating every doctor with the respect that is due all doctors unless he proves to the medical society that he does not deserve it. This is the Old Code of Ethics for the Medical Profession, and even today it is—*fundamental.*

## Research

Medical research in America is big business. It is carried on by all medical schools and allied institutions, hospitals, foundations, clinics, pharmaceutical concerns, and chemical industries. The results have paid rich dividends in the improved health and financial status of our country. There are political gains also; good will toward the United States is engendered by each wonder drug and other new remedy we send to a foreign land.

Money for this type of research comes from various sources. Integration of these funds is lacking so that duplication and overlapping occur. Foundations endowed by philanthropists do not pool their experiences and often waste millions before learning that research in the paper plan stage differs from the actual needs.

The public also has contributed generously but they do not always support the most vital projects. They are attracted to the campaigns that arouse sympathy, which explains why the National Foundation for Infantile Paralysis is so successful despite that fact that more people die of heart disease in one day than of polio in one year.

Government money is becoming more readily available but some medical administrators are wary of the possible strings attached. The larger and richer states tend to be more generous and give their institutions greater leeway. The poorer states frequently insist that the money be spent for research on local projects. Political and economic pressure sometimes play a role. In Wisconsin, for example, considerable research is done along agricultural lines. This work has been of help to medicine, however; dicoumarol was discovered as a by-product of the study of sweet clover disease of cattle, which had caused bleeding in these animals and death of whole herds. The Markle Foundation is unique in contributing long-term fellowships to encourage recent graduates to enter the academic field.

Good research men are difficult to obtain. Many are born investigators who are able to work relentlessly on a given problem. They usually have wide knowledge based on previous academic work, and have the intellectual curiosity of scholars. A noted contributor to mathmatical thought was asked how he was able to accomplish what he did. His answer was simple: "By thinking about it all the time." Chance dis-

coveries have occurred but the majority have been evolved by inspired investigators who are perfectionists, if not geniuses, devoting all their time and energy to attaining their objectives.

But despite the changing trend in research, the results will always depend upon the knowledge and integrity of those who do the work.

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## The golden anniversary of the FDA

We salute the Federal Food and Drug Administration on its 50th anniversary. This group, less than 1,000 strong, has come a long way since its inception in 1906. The Federal Food and Drug Act was passed because of the irresponsibility and lack of social conscience of many manufacturers who were more concerned with immediate financial gains than with the continuing welfare of their customers.

Federal legislation has helped the physician as well as reputable manufacturers. It requires adequate and truthful labeling of foods, drugs, and cosmetics and serves as a basis for the establishment of high standards of safety of foods and drugs.

Almost every physician encounters some provision of the law. It prohibits the sale and dispensing of certain drugs without a proper prescription from a physician licensed to administer such medications. It prevents refills of dangerous drugs and discourages over-the-counter buying of potentially harmful products like the amphetamines, barbituates, and sex hormones. The agency wages constant warfare against the cancer quack, the diet faddist, and the sale of fraudulent and hazardous medical devices.

The medical profession does not always see eye to eye on many points but few of its members will fail to agree that the principles behind the law have gone a long way toward improving the integrity of those who make, sell, and prescribe drugs, foods, and cosmetics. The result is protection of the consumer, increased consumer confidence in the products of reliable manufacturers, and the restriction of unethical competition.

Numerous manufacturers are joining in a tribute to Dr. Harvey W. Wiley, the crusader who carried the torch for so many years for the attainment of purity and safety of our foods and drugs.

## Our New Public Relations Director

On April 1, Mr. Edward A. Uzemack of 8046 Kenneth Avenue, Skokie, assumed the duties of Public Relations Director of the Illinois State Medical Society, and was given the designation of Assistant Secretary by the Council. Mr. Uzemack has been with the American Medical Association for the past three years, where his designation was executive assistant in the Public Relations Department, assigned to work directly with the presidents of the A.M.A.

Prior to joining the A.M.A., he had worked for two years as a public information officer for the Chicago Region of the Office of Price Stabilization. For 14 years previous to that assignment, he was a news reporter and rewriteman for the Chicago Times and the Chicago Sun-Times. He lives in Skokie with his wife and three children.

Mr. Uzemack as assistant Secretary will be responsible for the general activities in the Chicago office of the Society, and will visit many component societies in Illinois with the Secretary. He will also attend most of the post graduate conferences where he hopes to meet the component society officers, and aid them in preparing their schedule of public relations activities. In this function, he succeeds James C. Leary who acted as P. R. Director for nearly 10 years, and who died in April, 1955.

County Society officers and their public relations committees will now be able to take their problems to Mr. Uzemack, and may address him in care of the Society Chicago office, Suite 1909, 185 North Wabash Avenue, Chicago 1, Illinois

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## A.M.A. Annual Meeting in Chicago, June 11-15, 1956

There will be many features presented at the 1956 Annual Meeting of the American Medical Association to be held in Chicago June 11-15.

The activities in general will be centered at the Navy Pier, Northwestern University and near north side hotels. Headquarters for the House of Delegates will be at the Palmer House.

The Illinois State Medical Society and the Chicago Medical Society are joint hosts for the meeting, and it is hoped that many members of the I.S.M.S. will plan to attend this largest of all medical meetings to be held in 1956.

# Preliminary Program

**for the**

**One Hundred Sixteenth**

# Annual Meeting

**of the**

# Illinois State Medical Society

**May 15, 16, 17, 18, 1956**

**Hotel Sherman** **Chicago**

# PROGRAM SUMMARY

## TUESDAY, May 15, 1956

7:30 Council Breakfast, Jade Room 103
9:00 Section on Eye, Ear, Nose and Throat, Crystal Room
Section on Cardiovascular Disease, Gold Room 114
Section on Anesthesiology, Emerald Room 104
Section on Obstetrics & Gynecology, Old Chicago Room 101
9:00 First Meeting — House of Delegates, Louis XVI Room
12:00 Luncheon, Section on Anesthesiology, Jade Room 103
1:30 General Assembly, The Ballroom
3:30 Section on Radiology, Crystal Room
6:00 Public Relations Dinner, Louis XVI Room
9:00 Program and Buffet Supper — In co-operation with Woman's Auxiliary, Bal Tabarin

## WEDNESDAY, May 16, 1956

8:00 Council Breakfast, Jade Room 103
9:00 Section on Pediatrics, Louis XVI Room
Section on Eye, Ear, Nose and Throat, Crystal Room
Section on Surgery, Old Chicago Room 101
Physicians Association, Dept. of Public Welfare, Gold Room 114
10:00 Reference Committees
1. Reports of Officers, Time Room 110
2. Reports of Councilors, Gold Coast 111
3. Standing Committees, Orchid Room 106
4. Reference Committee "A", Holiday Room 105
5. Reference Committee "B", Emerald Room 104
6. Reference Committee "C", Jade Room 103

12:00 Illinois Chapter, American Academy of Pediatrics, Louis XVI Room
Fifty Year Club Luncheon, Crystal Room
11:45 Illinois Chapter, American Academy of General Practice luncheon, Assembly Room
1:30 General Assembly, The Ballroom
7:00 Annual Dinner, The Ballroom

## THURSDAY, May 17, 1956

8:00 Council Breakfast, Jade Room 103
Women Physicians' Breakfast, Emerald Room 104
9:00 Section on Preventive Medicine & Public Health, Louis XVI Room
Section on Allergy, Crystal Room
Section on Medicine, Gold Room 114
Section on Dermatology, Old Chicago Room 101
10:00 Illinois Chapter, American College of Chest Physicians, Ruby Room 113
10:00 Reference Committees
1. Reference Committee "D", Jade Room 103
2. Reference Committee "E", Orchid Room 106
3. Miscellaneous Business, Holiday Room 105

12:00 Luncheon, Illinois Chapter, American College of Preventive Medicine, Louis XVI Room
Luncheon, Illinois Chapter, American College of Chest Physicians, Emerald Room 104
Luncheon, Section on Dermatology, Old Chicago Room 101
Luncheon — Phi Chi Fraternity, Room 107
1:30 General Assembly, The Ballroom
3:00 Second Meeting — House of Delegates, Louis XVI Room
7:00 Loyola Alumni Dinner, The Crystal Room

## FRIDAY, MAY 18, 1956

8:30 Third Meeting — House of Delegates, Louis XVI Room
9:00 Section on Pathology, Crystal Room
Red Cross Disaster Program, Chicago Room 101
12:00 Luncheon — Section on Pathology, Crystal Room
12:30 Council Luncheon, Gold Room 114
2:00 Illinois Association of Blood Banks, Louis XVI Room

***So many things to see, hear, do!***

# Meetings of the House of Delegates

## Louis XVI Room

### (1) Tuesday, May 15, 1956

9:00 a.m.

The first meeting of the House of Delegates will be called to order by the President, F. Garm Norbury for:
The appointment of Reference Committees
The Reports of Officers, Councilors, Committees, etc.
The introduction of Resolutions, and for the transaction of any other business which may come before the House
THE COMMITTEE ON CREDENTIALS will meet at 8:00 a.m. Tuesday morning, May 15, in the entrance way to the Louis XVI Room. Delegates desiring to be certified as the official representatives of their county medical societies must present their credential cards to this committee

### (2) Thursday, May 17

3:00 p.m.

The Second meeting of the House of Delegates will be called to order by the President to hear those reports of Reference Committees ready to be presented.

### (3) Friday, May 18

8:30 a.m.

The third (and last) meeting of the House of Delegates will be called to order by the President to hear those reports of Reference Committees remaining to be presented;
For the Election of Officers, Councilors, Committees, Delegates and Alternates to the American Medical Association, and for the transaction of any other business to come before the House.
At the close of this last meeting, F. Lee Stone will be installed as the new President of the Illinois State Medical Society, and will receive the official gavel from the retiring President, F. Garm Norbury.

# Programs For Tuesday, May 15, 1956

## SECTION ON EYE, EAR, NOSE AND THROAT

Chairman ..... Fletcher Austin, Chicago
Secretary ..... G. LeRoy Porter, Urbana

CRYSTAL ROOM
Tuesday Morning May 15, 1956

9:00 "The Evolution of Stapes Mobilization Therapy"
EUGENE L. DERLACKI, Assistant Professor of Otolaryngology, Northwestern University Medical School, Chicago
9:20-9:30 Discussion

9:30 "Progress in the Control of Retrolental Fibroplasia in Illinois"
J. ROBERT FITZGERALD, Supervising Ophthalmologist, Illinois Public Aid Commission; Assistant Professor of Ophthalmology, Stritch School of Medicine, Loyola University, Chicago
9:50-10:00 Discussion

10:00 "Hemorrhage Following Otolaryngologic Surgery"
WILLIAM H. WEISS, Springfield
10:20-10:30 Discussion

10:30 "Medical Ophthalmoscopy Clinic" — (Illustrated)
HENRY P. WAGENER, Emeritus Consultant in Ophthalmology, Mayo Clinic, Rochester, Minnesota
11:00-11:15 Discussion

11:15 BUSINESS MEETING and Election of 1956 Section Officers
Section Officers

11:30 ADJOURNMENT TO VIEW EXHIBITS

## SECTION ON CARDIOVASCULAR DISEASE

Chairman ..... Chauncey C. Maher, Chicago
Secretary ..... Emmet F. Pearson, Springfield

GOLD ROOM 114
Tuesday Morning, May 15, 1956

9:00 "The Heart in Poliomyelitis"
GERSHOM K. GREENING, Springfield

9:20 "Prevention of Myocardial Infarction"
OGLESBY PAUL, Chicago

9:40 "High Blood Pressure vs. Hypertensive Disease"
JESSE C. LOCKHART, Peoria

10:00 RECESS TO VIEW EXHIBITS

10:30 "The Coronary Artery Reconsidered"
E. GREY DIMOND, Kansas City, Kansas

11:15 "Extra Cardiac 'Heart Attacks'"
EARLE GRAY, Chicago

11:35 "Question and Answer Period
E. GREY DIMOND
GERSHOM K. GREENING
OGLESBY PAUL
JESSE C. LOCKHART
EARLE GRAY

11:50 BUSINESS MEETING and Election of 1957 Section Officers.

## SECTION ON ANESTHESIOLOGY

Chairman ..... Arthur T. Shima, Oak Park
Secretary ..... E. M. Dewhirst, Danville
Alternate ..... Mary Karp, Chicago

EMERALD ROOM 104
Tuesday Morning, May 15, 1956

9:00 Opening of the Section meeting

9:10 "Nitrous Oxide, Cyclopropane Anesthesia"
BRYCE OZANNE, Moline

9:40 "Problems in Anesthesia of the Aged"
PAUL H. LORHAN, Professor of Surgery (Anesthesiology) and Chief, Section of Anesthesiology, University of Kansas School of Medicine, Kansas City

10:10 RECESS TO VIEW EXHIBITS

10:40 "Anesthesia for Emergency Surgery in Children"
ROBERT M. SMITH, Children's Medical Center, Boston, Massachusetts

11:10 "Pain"
F. A. DUNCAN ALEXANDER, Associate in Anesthesia, State University of Iowa, University Hospitals and Veterans Administration Hospital, Iowa City

11:40 Business meeting for the election of 1957 Section Officers.

12:00 Section Luncheon, Jade Room 103

## SECTION ON OBSTETRICS AND GYNECOLOGY

Chairman ..... Charles D. Krause, Chicago
Secretary ..... Carl Greenstein, Champaign

OLD CHICAGO ROOM 101
Tuesday Morning, May 15, 1956

9:00 "Pelvic Tumors Complicating Pregnancy"
HENRY A. LATTUADA, Attending Obstetrician and Gynecologist Lakeview Hospital, Danville

9:20 "Recent Impressions Concerning Diseases of the Ovaries"
BRADLEY SYLVESTER, Attending Obstetrician & Gynecologist, St. Joseph's Hospital, Joliet

9:40 "Air Embolism Associated with Pregnancy"
JACK D. BRODSKY, Attending Obstetrician and Gynecologist, Burnham City Hospital, Champaign

10:00 RECESS TO VIEW EXHIBITS

10:30 PANEL DISCUSSION: "Obstetrical Hemorrhage"
Moderator: WILLARD C. SCRIVNER, Attending Obstetrician and Gynecologist, St. Mary's Hospital, East St. Louis.
FREDERICK H. FALLS, Chicago
WILLIAM J. DIECKMANN, Chicago
HUBERT L. ALLEN, Alton
WILLIAM COOLEY, Jr., Peoria

11:30 Business Meeting and Election of 1957 Section Officers.

## SECTION ON RADIOLOGY

Chairman ..... Fred H. Decker, Peoria
Secretary .... Hildegarde A. Schorsch, Chicago

CRYSTAL ROOM
Tuesday Afternoon, May 15, 1956

3:30 p.m.

Guest moderator of the film reading session of the Section on Radiology will be CHESTER H. WARFIELD, Director of the Department of Radiology at St. Joseph's Hospital, Fort Wayne, Indiana. He is also Consultant Radiologist at the Veterans' Hospital in Fort Wayne.

Following the scientific portion of the program, a business meeting and the election of Section Officers for 1957 will be held.

# General Assembly

THE BALLROOM

Tuesday Afternoon, May 15, 1956

Presiding: ..... Charles D. Krause, Chicago
Assisting: ..... Arthur T. Shima, Oak Park

1:30 Opening of the General Assembly
F. GARM NORBURY, Jacksonville. President, Illinois State Medical Society

1:40 "Roentgen Evaluation of the Chest"
CHESTER H. WARFIELD, Fort Wayne, Indiana. Director, Department of Radiology, St. Joseph's Hospital Consultant Radiologist, Veterans Hospital of Fort Wayne

2:00 "Urinary Incontinence in the Female"
JOHN C. ULLERY, Columbus, Ohio. Professor and Chairman of Department of Obstetrics and Gynecology, Ohio State University College of Medicine

2:20 "Anesthetic Consideration in the Acutely Injured Patient"
HARVEY C. SLOCUM, Colonel, USA MC, Washington, D.C. Chief Consultant in Anesthesia to the Surgeon General, Chief of Anesthesia and Operating Section, Walter Reed Army Hospital

2:40 RECESS TO VIEW EXHIBITS

Presiding: ..... Fletcher Austin, Chicago
Assisting: ..... Fred H. Decker, Peoria

3:30 "Acute Coronary Occlusion Reconsidered"
E. GREY DIMOND, Kansas City, Kansas Professor of Medicine and Head of Department of Medicine, University of Kansas School of Medicine

3:50 "Gamma Globulin in Disease"
ROBERT GOOD, Minneapolis, Minnesota, Director of Pediatric Research, University of Minnesota Medical School

4:10 "Physiology of Transient Loss of Vision"
HENRY P. WAGENER, Rochester, Minnesota, Emeritus Consultant in Ophthalmology, Mayo Clinic.

***Here's an interesting and entertaining evening planned just for you —***

**PUBLIC RELATIONS DINNER**

LOUIS XVI ROOM

Tuesday Evening, May 15, 1956

6:30 p.m.

The Public Relations Dinner (scheduled by the Committee on Medical Service and Public Relations of the Illinois State Medical Society) will be held for the fourth consecutive year.

Any member of the Society interested in public relations and the many phases of this important field, will be most welcome at the dinner.

The program is being planned by the Chairman of the Committee, Dr. Percy E. Hopkins of Chicago, assisted by the new Public Relations Director of the Society, Edward A. Uzemack.

Dinner tickets will be sold for $3.00 each, with the Illinois State Medical Society absorbing the remainder of the cost for the dinner.

Reservations may be made by writing to Mr. Uzemack at the Chicago Office of the Illinois State Medical Society, Suite 1909, 185 North Wabash Avenue, Chicago.

**PROGRAM AND BUFFET SUPPER**

BAL TABARIN

Tuesday Evening, May 15, 1956

9:00 p.m.

Instead of the Hospitality Hour scheduled on Tuesday evening in former years, the WOMAN'S AUXILIARY to the Illinois State Medical Society, working with the Liaison Committee from the State Society headed by Dr. Frederic M. Nicholson of Chicago, are planning a program and buffet supper.

The Auxiliary has planned several "skits" and the general theme of their evening program will be to honor the physicians with whom they have worked during the past year.

Mrs. Nicholas G. Chester of Oak Park is the Chairman selected by the Auxiliary to plan the evening's entertainment.

# Programs For Wednesday, May 16, 1956

## SECTION ON PEDIATRICS

Chairman ..... J. Keller Mack, Springfield
Secretary ..... Noel G. Shaw, Evanston

LOUIS XVI ROOM
Wednesday Morning, May 16, 1956
Joint Meeting with Section on Medicine

9:00 "Jaundice in the Newborn"
HAROLD D. PALMER, Pathologist, St. John's Hospital, Springfield

9:20 "Treatment of Burns in Children" (Kodachromes)
FRANK PIRRUCELLO, St. Francis Hospital, Evanston

9:40 "Experience with Salk Vaccine in Illinois in 1955"
RUTH CHURCH, Chief, Bureau of Communicable Disease Control, State Department of Public Health, Springfield.

10:00 "Reticuloendotheliosis in Children"
HEYWORTH N. SANFORD, Chairman, Department of Pediatrics, University of Illinois College of Medicine, Chicago.

10:20 RECESS TO VIEW EXHIBITS

10:50 SYMPOSIUM ON THE USE OF STEROIDS
Moderator: JOHN S. BIGLER, Medical Director, Children's Memorial Hospital, Chicago

"The Uses and Abuses of ACTH and Cortisone in Children"
ROBERT GOOD, Director of Pediatric Research, University of Minnesota College of Medicine, Minneapolis.

"Steroids in the Treatment of Nephrosis"
SMITH FREEMAN, Professor of Biochemistry, Northwestern University Medical School, Chicago

"The Use of ACTH and Cortisone in Rheumatic Fever"
EUGENE STOLLERMAN, Northwestern University Medical School, Chicago

12:15 BUSINESS MEETING, and Election of Section officers of 1957.

12:30 LUNCHEON — Illinois Chapter, American Academy of Pediatrics.
All physicians interested in problems and welfare of children are invited to attend.

## SECTION ON EYE, EAR, NOSE AND THROAT

Chairman ..... Fletcher Austin, Chicago
Secretary ..... G. LeRoy Porter, Urbana

CRYSTAL ROOM
Wednesday Morning, May 16, 1956

9:00-11:30 SYMPOSIUM: NEUROLOGIC COMPLICATIONS OF EYE, EAR, NOSE AND THROAT

MODERATOR: DERRICK T. VAIL, Professor and Head of the Department of Ophthalmology, Northwestern University Medical School, Chicago

PANEL: "Clinical Aspects of Neuralgia of the Head" ROLOND P. MACKAY, Professor of Neurology, University of Illinois College of Medicine, Chicago "Cerebral Angiography from Viewpoint of the Neurosurgeon".

JOSEPH P. EVANS, Professor of Neurological Surgery, University of Chicago School of Medicine, Chicago "Clinical Lesions of the Oculomotor Nerve."

JOSEPH E. ALFANO, Clinical Assistant in Ophthalmology, University of Illinois College of Medicine, Chicago "Cerebral Angiography"

FAY H. SQUIRE, Clinical Professor of Radiology (Rush), University of Illinois College of Medicine, Chicago "Neurological Complications from Otolaryngologic Aspect"

BURTON J. SOBOROFF, Assistant Professor of Otolaryngology, University of Illinois College of Medicine, Chicago

11:30 ADJOURNMENT TO VIEW EXHIBITS

## SECTION ON SURGERY

Chairman ..... Cornelius M. Annan, Chicago
Secretary ..... David A. Bennett, Canton

OLD CHICAGO ROOM 101
Wednesday Morning, May 16, 1956

9:00 "A New Technique in the Management of Severe Pelvic Fractures"
WILLIAM JOHNSON, Galesburg Clinic, Galesburg.

9:15 "Surgical Treatment of Pulmonary Cysts and Spontaneous Pneumothorax"
ROBERT A. DeBORD, Surgical Staff, St. Francis Hospital, Peoria

9:30 "Vascular Problems Encountered in Abdominal Surgery"
JAMES S. CLARKE, Assistant Professor of Surgery, University of Chicago School of Medicine, Chicago

9:45 "Pitfalls in Abdominal Surgery"
HARRY A. OBERHELMAN, Professor

and Chairman, Department of Surgery, Stritch School of Medicine, Loyola University; Mercy Hospital, Chicago.

10:00 RECESS TO VIEW EXHIBITS

10:30 PANEL DISCUSSION ON GALL BLADDER DISEASE

MODERATOR: WARREN H. COLE, Professor and Head of Department of Surgery, University of Illinois College of Medicine; Illinois Research Hospitals, Chicago

Collaborators:

EVERETT P. COLEMAN, Coleman Clinic, Graham Hospital, Canton

ARKELL M. VAUGHN, Clinical Professor of Surgery, Stritch School of Medicine, Loyola University; Senior Surgeon, Mercy Hospital, Chicago

WALTER G. MADDOCK, Professor of Surgery, Northwestern University Medical School; Wesley Memorial Hospital, Chicago

L. S. HELFRICH, Moline

11:45 Business Meeting and Election of 1957 Section Officers.

## THE PHYSICIANS' ASSOCIATION

of the
Department of Public Welfare,
State of Illinois
GOLD ROOM 114
Wednesday Morning, May 16, 1956

J. W. Klapman, President, Chicago
S. J. Lipnitzky, Secretary-Treasurer, Dixon
Werner Tuteur, Program Director, Elgin

1. "The Autonomic Nervous System and Immunity"
   S. LOUMOS, M.D.
2. "Carbon Dioxide in the Treatment of Neurotic Disturbances"
   ROCHUS STILLER, M.D.
3. "A Case of Fatal Agranulocytosis due to Chlorpromazine"
   WERNER TUTEUR, M.D.
4. "Availability of Hostile Fantasy Related to Overt Behavior"
5. "Jujunal Motility Patterns"
   A. J. Glazebrook
6. "A Study in the Validation of the Lie Scale"
   Mr. E. Kurtz, psychologist at Manteno.
   PAUL KANE, Ph.D.

## FIFTY YEAR CLUB LUNCHEON

CRYSTAL ROOM
Wednesday Noon, May 16, 1956 12:00

Andy Hall, Chairman of the Fifty Year Club since its formation in 1937, will preside again this year at the annual complimentary luncheon honoring the members of the FIFTY YEAR CLUB.

All physicians who have been in the practice of medicine for fifty years or more are invited as guests of the Illinois State Medical Society at one of the most popular social functions held during the annual meeting.

Tickets for the luncheon are complimentary and may be secured at the ticket desk during the first day of the meeting, or from Doctor Hall.

## ILLINOIS ACADEMY OF GENERAL PRACTICE

The Assembly Room
Wednesday Noon, May 16, 1956

There will be a luncheon meeting of the Illinois Academy of General Practice at 11:45 o'clock on Wednesday, May 16, 1956, in the Assembly Room on the mezzanine floor of the Hotel Sherman.

Since this meeting must adjourn at 1:15 in order that the physicians in attendance may be present in the General Assembly by 1:30, the luncheon will start on time, as listed.

Members of the Academy and their friends may make their reservations now with their Regional Chapter Secretary.

It is hoped that the first meeting of the Illinois Academy of General Practice to be held in connection with the annual meeting of the Illinois State Medical Society will be a successful one.

***Why not make your reservations at the Hotel Sherman now?***

# General Assembly

THE BALLROOM

Wednesday Afternoon, May 16, 1956

Presiding: ..... J. Keller Mack, Springfield

Assisting: ..... Fred Long, Peoria

1:30 THE PRESIDENT'S ADDRESS:
F. GARM NORBURY, Jacksonville. President, Illinois State Medical Society

1:50 THE ORATION IN SURGERY:
BROWN M. DOBYNS, Cleveland, Ohio. Professor of Experimental Surgery, Western Reserve University School of Medicine

2:30 THE ORATION IN MEDICINE:
CHARLES H. RAMMELKAMP, Cleveland, Ohio. Professor of Medicine and Public Health, Western Reserve University School of Medicine

2:50 RECESS TO VIEW EXHIBITS

Presiding: ..... Cornelius M. Annan, Chicago

Assisting: ..... David A. Bennett, Canton

3:10 SYMPOSIUM ON PREVENTION AND TREATMENT OF AUTOMOBILE ACCIDENTS

1. "The Auto Crash Injury Research Program" — five minute review.
SERGEANT ELMER C. PAUL, Supervisor of Auto Crash Injury Research Section, Indiana State Police, Indianapolis, Indiana

"Causes of Occupant Injuries" narration with slides
SERGEANT PAUL

2. "The Search" — black and white film showing results of CORNELL UNIVERSITY RESEARCH DIVISION on crash injuries and results of field and laboratory studies. Runs 27 minutes.

3. "Drivers, Drinks and Drugs"
W. J. R. CAMP, M.D., Ph.D., Chicago. Professor of Pharmacology and Toxicology, University of Illinois School of Medicine. State Toxicologist.

4. "The Immediate Care of Maxillofacial Injuries"
WAYNE B. SLAUGHTER, D.D.S., M.D., Chicago. Chairman, Department of Plastic Surgery, Stritch School of Medicine, Loyola University

5. "Injuries of the Lower Urinary Tract"
WILLARD EASTON, Peoria

**THE ANNUAL DINNER**

THE BALLROOM

Wednesday, May 16, 1956

7:00 p.m.

Arkell M. Vaughn, Immediate Past President ... ..... Toastmaster

Invocation

"The Human Side of Medicine"

Guest Speaker: ELMER HESS, President, American Medical Association, Erie, Pennsylvania

Introduction of Past Presidents and Guests ... ..... Arkell M. Vaughn

Presentation of President's Certificate to F. GARM NORBURY .... By Joseph T. O'Neill
Chairman of the Council

Dinner Music

# Programs For Thursday, May 17, 1956

## WOMEN PHYSICIANS' BREAKFAST

EMERALD ROOM 104

Thursday Morning, May 17, 1956

8:00 a.m.

On Thursday morning, May 17, the Women Physicians registered at the 1956 annual meeting will be the guests of the Illinois State Medical Society at a breakfast meeting.

This annual breakfast has been held for several years, and the women physicians in attendance have enjoyed a complimentary breakfast and short and informal program before the scientific sessions for the day open at 9:00 a.m.

Dr. Elizabeth R. Fischer, of Chicago is the Chairman for this year's meeting.

## SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

Chairman ..... Fred Long, Peoria
Secretary ..... Herbert Ratner, Oak Park

LOUIS XVI ROOM

Thursday Morning, May 17, 1956

9:00 a.m.

"Host-Contaminant Relationships"
PROF. JAMES A. REYNIERS, Research Professor of Bacteriology, Director of Lobund Institute University of Notre Dame, Notre Dame, Indiana

"Vital Statistics and the Etiology of Heart Disease"
JEREMIAH STAMLER, Assistant Director of Cardiovascular Department, Medical Research Institute, Michael Reese Hospital; Established Investigator of the American Heart Association, Chicago

"Tuberculosis Control in 1956"
EDWARD A. PISZCZEK, Suburban Cook County Tuberculosis Sanatorium District; Professor of Preventive Medicine and Public Health, Stritch School of Medicine, Loyola University, Chicago.

11:45 BUSINESS SESSION and Election of 1957 Section Officers.

12:00 Adjournment.

## SECTION ON ALLERGY

Chairman .....Milton M. Mosko, Chicago
Secretary .....Leonard Harris, Peoria

CRYSTAL ROOM

Thursday Morning, May 17, 1956

9:00 a.m.

1. "Why is Asthma Frequently Worse from October through Christmas?"
HARRY LEE HUBER, Chicago
2. "The Management of Allergic Diseases without Antihistaminics, Adrenal Steroids or Antibiotics"
ESTHER PIZER, Chicago Medical School, Chicago
3. "The Complications of Adrenal Steroid Therapy in Practice" (The Results of a questionnaire).
BENJAMIN GORDON, Stritch School of Medicine, Chicago
4. "How Important are Emotional Factors in Allergic Diseases of Children?" A SYMPOSIUM
HENRY FEINBERG, Northwestern University
TOWNSEND FRIEDMAN, Northwestern University
JOHN HYDE, University of Illinois
HOWARD LEE, Marquette University

Business Meeting and election of Section Officers for 1957.

## SECTION ON MEDICINE

Chairman ..... Jacques M. Smith, Chicago
Secretary ..... Robert M. Hoyne, Urbana

GOLD ROOM 114

Thursday Morning, May 17, 1956

SECTION ON PEDIATRICS — By Invitation.

9:00 SYMPOSIUM ON ANTIBIOTICS
MODERATOR: HARRY F. DOWLING Professor of Medicine, and Head of Department, University of Illinois College of Medicine, Chicago
PAUL S. RHOADS, Professor of Medicine, Northwestern University Medical School; Chief of Medicine Wesley Memorial Hospital, Chicago
L. MARTIN HARDY, Representing the Section on Pediatrics, Associate Professor of Pediatrics, Northwestern University Medical School, Chicago.

10:00 RECESS TO REVIEW EXHIBITS

10:30 "Recent Developments in Hepatitis"
RICHARD B. CAPPS, Professor of Medicine, Northwestern University Medical School, Chicago

11:00 "Psychiatric Problems Encountered in Adolescence"
VIRGINIA TARLOW, Associate Professor of Psychiatry, University of Illinois College of Medicine, Chicago

11:30 Business Meeting and Election of 1957 Section Officers.

## SECTION ON DERMATOLOGY

Chairman .... James Herbert Mitchell, Chicago
Secretary ..... Malcolm Spencer, Danville

OLD CHICAGO ROOM 101
Thursday Morning, May 17, 1956

SYMPOSIUM — THE MANAGEMENT OF COMMON SKIN DISEASES

9:30 "Some Disorders of the Scalp"
JAMES HERBERT MITCHELL, Chicago. Chairman, Section on Dermatology

10:00 "The Skin: An Index of Visceral Changes"
WILLIAM K. FORD, Rockford
Discussant: Jerome Sickley, LaSalle

10:30 "The Changing Outlook of Pemphigus"
SAMUEL M. BLUEFARB and LEONARD HOYT, Chicago
Discussant: Richard B. Stoughton Chicago

11:00 RECESS TO VIEW EXHIBITS

11:30 PANEL: "The Management of the Scaling Eruptions"
The panel will stress the treatment of the following: Psoriasis, Seborrheic Dermatitis, Pityriasis Rosea and Lichen Planus.

Kodachromes of examplary cases will be presented for discussion.

MODERATOR: James Herbert Mitchell, Chairman, Section on Dermatology
Hans M. Buley, Christie Clinic, Champaign
John M. McCuskey, Peoria
Hilliard M. Shair, Physicians and Surgeons Clinic, Quincy
John H. Lamb, Oklahoma City, Guest of the Section on Dermatology.

12:30 LUNCHEON for members of the Section and their guests.
BUSINESS MEETING and election of 1957 Officers for Section on Dermatology

**Illinois Chapter**
**AMERICAN COLLEGE OF CHEST PHYSICIANS**
RUBY ROOM 113
Thursday Morning, May 17, 1956

10:00 a.m.
PANEL DISCUSSION: "The Problem of the Patient with Irremovable Pulmonary Carcinoma"

MODERATOR: WILLIAM M. LEES, Chief of Surgery, Municipal Tuberculosis Sanatorium, Chicago. Associate Professor of Surgery, Stritch School of Medicine, Loyola University, Chicago.
HAROLD C. VORIS, Professor of Neurosurgery, Stritch School of Medicine, Loyola University, Chicago
LEWIS HAAS, Associate Professor of Radiology, University of Illinois College of Medicine, Chicago
MARC H. HOLLENDER, Chief of Liaison Service, Neuropsychiatric Institute, University of Illinois College of Medicine, Chicago.
WILLIAM WALSH, Chief of Tumor Service, Hines Veterans Administration Hospital, Hines.

12:00 LUNCHEON in The Emerald Room No. 104
Brief business meeting with adjournment at 1:15 p.m.

**LUNCHEON**
**Illinois Chapter**
**AMERICAN COLLEGE OF PREVENTIVE MEDICINE**
LOUIS XVI ROOM
Thursday noon, May 17, 1956

**PHI CHI FRATERNITY LUNCHEON**
ROOM 107
Thursday noon, May 17, 1956

The Phi Chi Fraternity will have a luncheon meeting on Thursday noon, May 17, in Room 107 on the first floor of the Hotel Sherman.

Dr. Jacob E. Reisch of Springfield, Editor of the Phi Chi Bulletin, will be in charge of the plans.

All members of the fraternity are welcome to attend.

***Show your wife her program — page 208 in this issue***

# General Assembly

THE BALLROOM
Thursday Afternoon, May 17, 1956
Presiding: Chauncey C. Maher, Chicago
Assisting: Jacques M. Smith, Chicago

1:30 "Germfree Research: A Basic Study in Host-Contaminant Relationship. The Germfree & Conventionally Contaminated Animal from Birth to Weaning."
PROFESSOR JAMES A. REYNIERS, South Bend, Indiana, Research Professor of Bacteriology, Lobound Institute, University of Notre Dame

1:50 "Unexpected and Sudden Deaths"
JERRY J. KEARNS, Chicago, Associate Professor of Clinical Pathology, University of Illinois School of Medicine; Pathologist, St. Elizabeth's Hospital.

2:10 "Cholelithiasis"
CHARLES G. JOHNSTON, Detroit, Michigan, Professor and Chairman of Department of Surgery, Wayne University of Medicine

2:50 RECESS TO VIEW EXHIBITS
Presiding: James Herbert Mitchell, Chicago
Assisting: Milton M. Mosko, Chicago

3:10 "Sunlight and its Effect on the Skin"
JOHN H. LAMB, Oklahoma City, Oklahoma; Clinical Professor of Dermatology, University of Oklahoma School of Medicine

3:30 "Complications of Chronic Bronchial Asthma"
VINCENT DERBES, New Orleans, Louisiana, Professor of Medicine, Tulane University of Louisiana School of Medicine; Visiting Physician, Charity Hospital.

3:50 "The Present Status of the Salk Poliomyelitis Program"
EDWARD KRUMBIEGEL, Milwaukee, Wisconsin, Health Commissioner of Milwaukee; Professor and Chairman of the Department of Public Health and Preventive Medicine, Marquette University School of Medicine.

**LOYOLA UNIVERSITY ALUMNI DINNER**
CRYSTAL ROOM
Thursday Evening, May 17, 1956

The Medical Alumni of Loyola University's Stritch School of Medicine will meet for their annual dinner during the convention of the Illinois State Medical Society, on Thursday evening, May 17, in the Crystal Room of the Hotel Sherman.

Dr. Maurice Hoeltgen of the class of 1932 is serving as chairman of the dinner.

Dinner will be served at 7:00 p.m., and the price is $6.50 per person.

**PHI BETA PI FRATERNITY SMOKER**

The annual Alumni-Fraternity smoker of the Phi Beta Pi Fraternity will be scheduled for Thursday evening, May 17 at the Chapter House, 710 Lake Shore Drive, Chicago.

Richard F. Chapman, alumni secretary, is completing the plans for the affair, and will make an announcement of the program for the evening in the May issue of the Illinois Medical Journal.

# Programs For Friday, May 18, 1956

**SECTION ON PATHOLOGY**
Chairman ..... Jerry J. Kearns, Chicago
Secretary ..... Frederick Bauer, Chicago
CRYSTAL ROOM
Friday Morning, May 18, 1956

9:00 a.m. PANEL DISCUSSION: METHODS OF FORENSIC PATHOLOGY FOR THE GENERAL PATHOLOGIST
(A review of methods of collecting evidence, disposition of evidence and other examinations that may be available when pathologists are called for a medico-legal autopsy. The discussions are planned to be practical and helpful).
MODERATOR: JERRY J. KEARNS, Associate Professor of Clinical Pathology, University of Illinois; Director of Pathology Laboratory, St Elizabeth Hospital, Chicago
1. Identification of Individuals, Stains, and Weapons. Lie Detection. LIEUTENANT JOHN ASCHER, Chief, Crime Detection Laboratory Chicago Police Department
2. Identification of Bones. A. A. ZIM-

MERMANN, PH.D., Professor of Anatomy, The University of Illinois, College of Medicine, Chicago

3. Identification of Blood Stains. ISRAEL DAVIDSON, Professor and Chairman, Department of Pathology, Chicago Medical School; Director, Department of Pathology, Mt. Sinai Hospital, Chicago
4. Medico-Legal Autopsy. EDWIN F. HIRSCH, Director of Pathology, St. Luke's Hospital, Chicago
5. Toxicological Examinations. WALTER J. R. CAMP, M.D., and Ph.D., Professor of Pharmacology and Toxicology, University of Illinois, College of Medicine; Toxicologist for the Coroner of Cook County and State of Illinois, Chicago
6. Legal Evaluation of Evidence from an Attorney's Point of View. IRWIN D. BLOCH, First Assistant State's Attorney of Cook County, Chicago.

Luncheon and Business Meeting — Election of Section Officers.

**THE DISASTER COMMITTEE**
**of the**
**Cook County Chapter**
**AMERICAN RED CROSS**
OLD CHICAGO ROOM 101
Friday Morning, May 18, 1956

PROGRAM ON "MASS CASUALTIES AND DISASTER PREPAREDNESS"

The final program for the Disaster Committee of the Cook County Chapter of the American Red Cross, will be published in the May issue of the Illinois Medical Journal. Part of the program will consist of a film presentation.

Dr. Franklin Lounsbury of Chicago is preparing the program material and completing the plans for the Red Cross.

**ILLINOIS ASSOCIATION OF BLOOD BANKS**
LOUIS XVI ROOM
Friday Afternoon, May 18, 1956

Scientific Program from 2:00 p.m. to 4:00 p.m.
Business Meeting from 4:00 p.m. to 5:00 p.m.

Details of the final program will be published in the May issue of the Illinois Medical Journal, and in the official program for distribution at the registration desk during the meeting.

# Technical Exhibitors

Abbott Laboratories, J. W. Addington, North Chicago, Booth 51.

American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Booth 24.

Audio-Digest Foundation, J. M. Burke, 800 N. Glendale Ave., Glendale, Calif., Booth 22.

Baby Development Clinic, Mrs. Hermien Nusbaum, 600 S. Michigan Ave., Chicago, Booth 8

Baker Laboratories, Inc. F. G. Rice, 4614 Prospect Ave., Cleveland, Ohio, Booth 59.

Blue Cross-Blue Shield Plan, Ruth Brannon, 425 N. Michigan Ave., Chicago, Booth 42-43.

Chicago Pharmacal Co., A. B. Taylor, 5547 N. Ravenswood Ave., Chicago 40, Booth 13.

Chicago Reference Book Co., 185 N. Wabash Ave., Chicago, Booth 67.

Ciba Pharmaceutical Products, Inc., J. Brownlee, 556 Morris Ave., Summit, N. J., Booths 48-49.

Chicago Seven-Up Bottling Co., J. E. Kenney, 300 W. 83rd St., Chicago, Booth 1.

The Coca Cola Company, J. T. Beers, P. O. 1734, Atlanta 1, Georgia, Booth 11.

Daniels Surgical & Medical Supplies, D. F. Roback, 3144 N. Narragansett Ave., Chicago, Booths 15, 16, 17.

Dayless Mfg. Co., Leslie Hoffman, 3257 N. Western Ave., Chicago 18, Booth 28.

Doho Chemical Corp., H. R. Steinmann, 100 Varick St., New York 13, Booth 10.

Eisele & Company, Thos. Hopkinson, 109 Spring St., Nashville, Tenn., Booth 7.

Eli Lilly & Company, Wm. D. Crooks, Indianapolis 6, Indiana, Booths 56-57.

Encyclopaedia Britannica, Joseph A. Wittchen, 14 E. Jackson Blvd., Chicago, Booth 69.

E. Fougera & Co., Inc., R. J. Chase, 75 Varick St., New York, Booth 9.

Geigy Pharmaceuticals, D. M. Beverly, 220 Church St., New York 13, Booth 32.

Health Insurance Council, J. R. Williams, 208 S. LaSalle St., Chicago 4, Booths 38-29.

H. J. Heinz Company, F. B. Heard, P. O. Box 57, Pittsburgh 30, Penn., Booth 3.

Lederle Laboratories Div., American Cyanamid Co,. W. H. Buch, Pearl River, N. Y., Booth 66.

Liebel-Flarsheim Co., C. A. Branham, 111 E. Amity Road, Cincinnati 15, Ohio. Booth 50.

J. B. Lippincott Co., G. H. Turner, E. Washington Square, Philadelphia 5, Pa., Booth 52.

S. E. Massengill Co., M. J. Hardwick, 527 Fifth St., Bristol, Tenn., Booth 27.

Mead Johnson & Co., H. C. Hallum, Evansville 21, Indiana, Booth 62.

Medco Products Co. Inc., L. S. DeGroff, 3603 E. Admiral Place, Tulsa 12, Okla., Booth 45.

Medical Aids, Inc., S. V. Bentley, 204 N. Northwest Highway, Park Ridge, Ill., Booth 58.

Medical Protective Co., R. E. Wright, Fort Wayne, Indiana, Booth 63.

V. Mueller Company, Wm. Merz, 320 S. Honore St., Chicago, Booth 46.

The National Drug Co., J. T. Bollettieri, Philadelphia, Pa., Booth 25.

National Live Stock & Meat Board, C. F. Neumann, 407 S. Dearborn St., Chicago 5, Booth 53.

National Production Co., H. George, 4561 St. Jean Ave., Detroit 14, Mich., Booth 12.

Nepera Chemical Co. Inc., G. J. Rohrmann, Nepera Park, Yonkers, N. Y., Booth 36.

Northern Illinois Medical Service, K. K. Clark, 227 N. Wyman St., Rockford, Booth 37.

Parke, Davis & Co., J. A. MacCartney, Detroit 32, Michigan, Booth 60.

Parker Aleshire & Co., E. T. Luehr, 175 W. Jackson Blvd., Chicago 4, Booth 6.

Pfizer Laboratories, G. F. Penny, 630 Flushing Ave., Brookyln 6, N. Y., Booth 55.

Professional Management, Peoples Bank Bldg., Bloomington, Ill., Booth 33.

Purdue Frederick Co., S. A. Lubman 135 Christopher St., New York 14, Booth 68.

R. J. Reynolds Tobacco Co., J. A. Vaughn, Winston-Salem, N. Carolina, Booth 14.

A. H. Robins Co., Edna M. Weems, 1407 Cummings Dr., Richmond 20, Va., Booth 2.

J. B. Roerig & Co., S. S. Sherman, 536 Lake Shore Drive, Chicago 11., Booth 31.

Sanborn Company, D. M. Beveridge, 122 S. Michigan Ave., Chicago 3, Booth 29.

Sandoz Pharmaceuticals, H. D. Davis, Route 10, Hanover, New Jersey, Booth 4.

W. B. Saunders Co., Anne Higgins, West Washington Square, Philadelphia 5, Pa., Booth 47.

Schering Corporation, Ralph Najarian, Bloomfield, New Jersey, Booth 64.

Julius Schmid, Inc., R. L. Waterfall, 423 West 55th St., New York 19, Booth 40.

G. D. Searle & Co., Bruce Beckman, P. O. Box 5110, Chicago 80, Ill., Booth 61.

Sharp & Dohme, D. M. Robertson, Philadelphia 1, Penna., Booth 54.

Sherman Laboratories, E. A. Lacey, 5031 Grandy Ave., Detroit 11, Michigan, Booth 26.

Smith, Kline & French Laboratories, T. L. Barsky, 1530 Spring Garden St., Philadelphia 1, Penna., Booth 19.

E. R. Squibb & Sons, Robt. Bessette, 745 Fifth Ave., New York, N. Y., Booth 21.

United States Tobacco Co., L. A. Bantle, 630 Fifth Ave., New York 20, Booth 35.

University of Chicago Press, Pat Daulton, 5750 Ellis Ave., Chicago 37, Booth 34.

The Upjohn Co., W. O. Miller, Kalamazoo 99, Michigan, Booth 65.

Vitamin Products Co., R. E. Grauel, 2023 W. Wisconsin Ave., Milwaukee 3, Wis., Booth 23.

Winthrop Laboratories Inc., J. J. Martocci, 1450 Broadway, New York 18, Booth 5.

The Zemmer Company, Wm. Addenbrook, 3943 Sennott St., Pittsburgh, Pa., Booth 30.

# Technical Exhibitors

### ABBOTT LABORATORIES
### Booth 51

A new nonbarbiturate hypnotic, PLACIDYL®, (Ethchlorvynol, Abbott) will be among the new products exhibited by Abbott Laboratories. Also shown will be NEMBU-SERPIN Filmtabs® (Nembutal® and Reserpine, Abbott), a new sedative, tranquilizer and antihypertensive; DESBUTAL®, a new mood-improvement drug; and ERYTHROCIN® Filmtabs (Erythromycin, Abbott), an antibiotic providing specific action against coccic infections and minimal risk of side effects.

Abbott also will exhibit IBEROL® Filmtabs containing intrisic factor concentrate, $B_{12}$, iron and other vitamins; OPTILETS® high-potency therapeutic multi-vitamins; VI-DAYLIN®, a homogenized mixture of seven vitamins; SELSUN®, for control of seborrheic dermatitis; PENTOTHAL® SODIUM, the intravenous anesthetic agent, and Abbott's complete line of intravenous solutions and equipment.

### AMERICAN HOSPITAL SUPPLY CORPORATION
### Booth 24

American Hospital Supply Corporation, Evanston, Illinois will present a display of Baxter Travert-Electrolyte Solutions, the new Therapeutic Vitamin B. Solution "Trinidex" and other Baxter parenteral therapy equipment including

the "Flashball" for simple needle insertion — and the $R^{48}$ blood pump and administration set".

### AUDIO-DIGEST FOUNDATION
**Booth 22**

Audio-Digest Foundation — a subsidiary of the California Medical Association — gives the busy physician an effortless tour through the best of current literature each week. This medical tape-recorded "newscast" — compiled and reviewed by a professional Board of Editors — may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally recognized authorities.

### BABY DEVELOPMENT CLINIC
**Booth 8**

Baby Development Clinic offers demonstration materials: products and literature helpful in instructing prospective parents in the physical and emotional aspects of parent-child relationships arising out of the daily care of their infants and children; also aids to assist in providing emotional security for their children through school ages.

USEFUL FOR: Parental Clinics; Prospective Parents Classes; Postpartum Teaching.

### BAKER LABORATORIES, INC.
**Booth 59**

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins, and other important factors which help to eliminate many of the problems in modern infant feeding.

### BLUE CROSS-BLUE SHIELD PLAN
**Booths 42 and 43**

### CHICAGO PHARMACAL COMPANY
**Booth 13**

Chicago Pharmacal Company (Chimedic) welcomes your visit to our booth which features the following specialties: URISED, nationally known antiseptic and sedative tablets for effective relief in genito-urinary infections; TOLYPHY, the improved muscle-relaxant in both tablet and liquid form; VERMIZINE, AMA-approved liquid vermifuge with the pleasing strawberry flavor; KATRASUL, the 4-sulfa combination in tablet and liquid form; plus a complete line of injectables, ointments, liquids and tablets awaiting your inspection.

### CHICAGO REFERENCE BOOK COMPANY
**Booth 67**

The Chicago Reference Book Company will feature MERRIAM-WEBSTER Dictionary, and the company shall be most pleased to have members of the Illinois State Medical Society stop at Booth 67 to visit with our representatives.

### CIBA PHARMACEUTICAL PRODUCTS, INC.
**Booths 48 and 49**

The CIBA exhibit features SERPASIL — the original, pure crystalline alkaloid of Rauwolfia. SERPASIL has been found extremely useful as a tranquilizer in treating patients whose adjustment to life is complicated by anxiety, irritability and various psychoses. Patients feel calm, yet in properly adjusted doses retain their drive and energy. It is highly effective in many conditions where barbiturates have been commonly prescribed.

### THE COCA-COLA COMPANY
**Booth 11**

Ice cold Coca-Cola served through the courtesy and co-operation of the Coca-Cola Bottling Company of Chicago, Inc., and The Coca-Cola Company.

### DANIELS SURGICAL AND MEDICAL SUPPLIES
**Booths 15, 16, 17**

DANIELS on the entire north end of the Exhibition Hall will feature this year "A MODEL DOCTOR'S OFFICE" featuring the newest and most modern type of medical furniture and equipment.

Such lines as MANILTON new medical furniture, RITTER'S "Time Saving" and "Energy Saving", electrically operated examining table. BURDICK'S E.K.G., New Ultra-Sonic and Micro Wave Units, Infra Red and Ultra Violet Lamps, and its D-54 Portable Diathermy — the sensational new EXAMINING LAMP "LUXO". "The Lamp of the Century".

AMERICAN AND CASTLE autoclaves and sterilizers. ROYAL METAL reception room, and JASPER consultation room furniture. The newest in Proctoscopes, Otoscopes, Headlamps, and WELCH ALLYN'S latest diagnostic equipment, its line of SKLAR instruments and top quality physicians' MEDICAL BAGS.

### DAYLESS MANUFACTURING COMPANY
**Booth 28**

### DOHO CHEMICAL CORPORATION
**Booth 10**

AURALGAN, the ear medication for the relief of pain of otitis media and removal of cerumen; NEW OTOSMOSAN, the effective, non-toxic ear medication which is fungicidal and bactericidal (gram negative-gram positive) in the suppurative

and aural dermatomycotic ears; RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged.

### EISELE AND COMPANY
**Booth 7**

Eisele & Company will display their regular line of clinical thermometers; hypodermic needles; hypodermic syringes, both regular and interchangeable; bandages and other medical specialties.

### ELI LILLY AND COMPANY
**Booths 56 and 57**

You are cordially invited to visit the LILLY exhibit located in spaces 56 and 57. The display will contain information on recent thrapeutic developments. LILLY sales people will be in attendance. They welcome your questions about LILLY products.

### ENCYCLOPAEDIA BRITANNICA, Inc.
**Booth 69**

ENCYCLOPAEDIA BRITANNICA proudly announces the biggest release in nearly 200 years. You are cordially invited to inspect in Booth 69 the New 1956 Edition of the Encyclopaedia Britannica. Year Book, World Atlas, and sample Research Reports will be available for inspection. Take advantage of SPECIAL EXHIBIT OFFER.

### E. FOUGERA & CO., Inc.
**Booth 9**

E. FOUGERA & COMPANY, INC., and DIVISION, VARICK PHARMACAL COMPANY, INC. cordially invite physicians to discuss with Professional Service Representatives new preparations of importance to their every day practice. Descriptive literature and samples of all products will be available.

### GEIGY PHARMACEUTICALS
**Booth 32**

MEDOMIN — a new kind of barbiturate — will highlight the GEIGY exhibit. Indicated for safe, gentle hypnosis and reliable, sustained sedation. MEDOMIN is unique in that a 7-member ring is attached to the barbiturate radical. Also featured will be BUTAZOLIDIN, nonhormonal anti-arthritic; EURAX, antipruritic and scabicide; and STEROSAN, bacteriostat and fungistat.

### HEALTH INSURANCE COUNCIL
**Booths 38 and 39**

Information on health insurance, including the new major medical expense policies, is readily available at the Health Insurance Council exhibit. You will see a graphic review of "The Health Insurance Story" and a clear picture of insurance company activities in helping insure the more than 100 million Americans with voluntary health insurance. The Health Insurance Council consists of nine insurance associations which represent companies providing various forms of voluntary health insurance in the United States.

### H. J. HEINZ COMPANY
**Booth 3**

WHAT'S NEW??? These Heinz Varieties:
Strained foods:
Bananas
Creamed Spinach
Macaroni, Tomatoes, Beef & Bacon
Split Peas — Vegetables & Bacon
Egg Yolk
Junior Foods:
Creamed Carrots
Teething Biscuit
Green Beans & Potatoes
Junior Dinner — Vegetables & Lamb
Junior Dinner — Vegetables & Liver
All Heinz Baby Foods are glass packed except Strained Orange Juice, Teething Biscuits and four Pre-Cooked Cereals.
Literature — Booket for Mothers — "A Feeding Guide for a Healthy Happy Baby" and for you — Nutritional Data.

### LEDERLE LABORATORIES DIVISION
**American Cyanamid Company**
**Booth 66**

You are cordially invited to visit the Lederle Booth where our medical representatives will be in attendence to provide the latest information and literature available on our line.

Featured will be Achromycin, Incremin, Diamox, Vitamins, Pathilon, Varidase and many other of our dependable quality products.

### THE LIEBEL-FLARSHEIM COMPANY
**Booth 50**

The Liebel-Flarsheim Company cordially invites you to visit Booth 50 in which their latest electromedical-electrosurgical equipment will be exhibited. We ask particularly that you stop and see the L-P BasalMeteR, the first automatic, self-calculating metabolism unit ever offered. Capable representatives will be on hand at all times.

### J. B. LIPPINCOTT COMPANY
**Booth 52**

J. B. Lippincott Company presents for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

## S. E. MASSENGILL COMPANY
### Booth 27

The S. E. Massengill Company will feature SALCORT and HOMAGENETS.

SALCORT, a safe, effective antiarthritic, is a judicious combination of salicylates and cortisone. It has all the advantages of both drugs plus the complementary action for greater therapeutic effect and fewer side effects.

HOMAGENETS, the homogenized vitamins. Now, for the first time the full advantages of a liquid vitamin dispersion can be obtained in a solid form. Better utilization, large excesses are unnecessary, no after taste, no burp, tastes like candy — may be swallowed, chewed or allowed to dissolve on the tongue.

## MEAD JOHNSON & COMPANY
### Booth 62

The new Deca vitamin family for the vital first decade of life will be exhibited by Mead Johnson & Company. Included in the new Deca family of vitamin specialties are: Deca-Vi-Sol, for dropper dosage, a fruit flavored solution for infants and toddlers; Deca-Mulcin, for teaspoon dosage, a pleasantly-flavored liquid for preschool children of two to six years; and Deca-Vi-Caps, small, easily-swallowed capsules, for school-agers of six to 10 years. All three Deca vitamin specialties supply ten nutritionally significant vitamins including A, C, and D, plus 7 important B vitamins.

## MEDCO PRODUCTS COMPANY, Inc.
### Booth 45

The MEDCOLATOR Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit our booth for a personal demonstration.

## MEDICAL AIDS, Inc.
### Booth 58

Medical Aids, Incorporated, will feature a complete line of pressure bandages, including the well known DALZOFLEX and PRIMER Combination, recommended in the treatment of leg ulcers, phlebitis, etc.; the NULAST elastic crepe bandage, constructed of Viscolax rubber threads; DALMAS elastic strapping, which is waterproof, oil and grease resistant; and DALMAPLAST plastic adhesive strapping.

## THE MEDICAL PROTECTIVE COMPANY
### Booth 63

An unparalleled record of successfully fighting malpractice charges against doctors since 1899 distinguishes The Medical Protective Company from all others. Year in and year out 99.94% of its policyholders have been completely covered under $2,500.00. Exclusive application to the professional liability field makes this unique record possible.

Messrs. Tom J. Hoehn, Fred A. Seeman, Walter R. Clouston and Edwin M. Breier will be in attendance at The Medical Protective Company booth.

## V. MUELLER COMPANY
### Booth 46

A display of instruments and equipment of particular value in general surgical practice will be presented by V. Mueller & Company (Chicago). Fine instruments — both standard and special — for almost every field of surgical practice will be included, as will some of the efficient and most widely used Mueller surgical pumps.

## NATIONAL DRUG COMPANY
### Booth 25

The National Drug Company presents products of original research at Booth 25. These "national" specialties include Parenzyme Intramuscular Trypsin, the direct, anti-edema, anti-inflammatory agent which has set new standards for the rapid and effective treatment of traumatic edema and acute inflammation. Parenzyme Intramuscular Trypsin is especially valuable in traumatic wounds, skin ulcers, ophthalmic inflammations, thrombophlebitis and phlebothrombosis.

Hesper-C represents a striking advance in the therapy of habitual abortion. Its use in one series of habitually aborting patients achieved a fetal salvage of 95%.

AVC Improved, effective in trichomonal, bacterial and monilial vaginal infections, also is featured.

## NATIONAL LIVE STOCK & MEAT BOARD
### Booth 53

This exhibit features the recommended daily food intake for adequate teen-age nutrition, showing their needs for protein and other nutrients to be one-third to one-half more than that of their parents. There will be a display of nutrition education materials which may be secured upon request.

## NATIONAL PRODUCTION COMPANY
### Booth 12

Featured at the National Production Company booth will be the original TEETERBABE, the only baby jumper seat with the S shaped springs which adjust to babies height and weight as they grow. This springy action provides baby with needed exercise for the legs and abdominal muscles to insure healthy growth.

Also shown are the JACK-N-JILL KIDDIE CHAIR, TEETERBABE STROLLER, KIDDIE

STEP, TRAVEL TOI and DOLLIEBABE all of which are useful for small children.

### NEPERA CHEMICAL COMPANY, Inc.
### Booth 36

The Nepera exhibit features — Biomydrin Nasal Spray, for effective mucolytic-penetrating antibacterial activity, prolonged nasal decongestion and antiallergic effect. Biomydrin F adds Hydrocortisone Alcohol to the Biomydrin Nasal solution formula, and is anti-inflammatory, antiallergic, mucolytic-penetrating, antibacterial and decongestant Biomydrin Otic, for the effective treatment of both otitis media and otitis externa, antibacterial, antiallergic, anti-inflammatory and penetrating. Choledyl, a new drug, has been highly effective in the treatment of bronchial asthma, bronchospasm and congestive heart failure. Choledyl assures high oral theophylline blood levels, with minimal side reactions; it rarely produces fastness. Urosulfin, a new product, which is a combination of a well known soluble sulfonamide for antibacterial effect and a widely-used azo dye for rapid symptomatic relief of pain, burning, frequency, etc., in the treatment of urinary infections. Mandelamine, a urinary antiseptic.

### NORTHERN ILLINOIS MEDICAL SERVICE, Inc.
### Booth 37

We cordially welcome all physicians to stop and visit our booth. We shall be happy to answer any Blue Shield questions that you may have.

Doctor — be sure to stop and pick up your "Blue Boutonniere" from Blue Shield.

### PARKE, DAVIS AND COMPANY
### Booth 60

Medical Service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Society. Important specialties, such as Penicillin S-R, Benadryl, Chloromycetin, Ambodryl, Dilantin Suspension, Vitamins, Oxycel, Milontin, Amphedase, Thrombin Topical, etc., will be featured.

You are cordially invited to visit our exhibit.

### PARKER, ALESHIRE & COMPANY
### Booth 6

ADMINISTRATORS OF THE SPECIAL SICKNESS AND ACCIDENT PLAN FOR MEMBERS OF THE ILLINOIS STATE MEDICAL SOCIETY.

Over $475,000 has been paid in claim benefits to insured members since the inception date, April 1, 1947. Your membership entitles you to participate in this successful plan.

You are cordially invited to visit our booth and ask our representatives for information about NEW — LONGER — NONCONFINING — PROTECTION recently made available This exceptional income protection is a "must" for every complete disability program.

### PFIZER LABORATORIES
### Booth 55

The Pfizer exhibit again will be in the spotlight with its new and original concept of anti-stress, anti-infective therapy — TETRACYN S. F. and TERRAMYCIN S. F. (Stress Fortified).

Also, the complete line of Pfizer antibiotics and STERAJECT as well as the new specialties, BONAMINE, TYZINE, TOCLASE and the complete line of steriod hormones including CORTRIL and the latest corticosteriod STERANE (brand of Prednisolone).

### PROFESSIONAL MANAGEMENT
### Booth 33

PROFESSIONAL MANAGEMENT — with over 23 years of specializing in the *Business Side of Medicine* invites you to stop at Booth 33, and meet Bert Cooper and Roger Peterson, resident partners in our Bloomington office.

Residents and interns, as well as physicians now in practice, are invited to consult with us.

(Affiliated with Black & Skaggs Associates, Inc. of Battle Creek, Michigan)

### THE PURDUE FREDERICK COMPANY
### Booth 68

The Purdue Frederick Company will feature:

SENOKOT new nonbulk, nonirritating, highly palatable constipation corrective acting selectively on the parasympathetic (Auerbach's) plexus in the large bowel, physiologically stimulating the neuromuscular defecatory reflex to reproduce natural bowel function;

PRE-MENS the multidimensional premenstrual tension therapy, correcting water retention, hypoglycemia and decreased protein metabolism characterizing this syndrome;

COLPOTAB a proven highly effective Tyrothricin trichomonacide and;

CHLOROGIENE — a hygienic douche formulation will also be presented.

### R. J. REYNOLDS TOBACCO COMPANY
### Booth 14

Welcome to the R. J. Reynolds Tobacco Company exhibit. You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, CAVALIER King Size, or WINSTON, the distinctive new king size filter cigarette.

### A. H. ROBINS COMPANY, Inc.
### Booth 2

The Robins exhibit features the Donnatal

"family" of antispasmodics, including the original tablets, capsules, the versatile elixir and the new Donnatal Extentabs, which provide all-day or all-night effects on single dosage; while the formula combined with B complex and indicated in the medical management of chronic fatigue states is available as Donnatal Plus. Also shown are Entozyme, Pabalate, Pabalate-Sodium Free and the new Pabalate-HC (Pabalate with Hydrocortisone).

### J. B. ROERIG AND COMPANY
**Booth 31**

Doctors and their friends are cordially invited to visit the J.B. ROERIG & COMPANY booth where information will be available on all the Roerig preparations. VITERRA TASTITABS, the all family vitamin. STIMAVITE, specially designed for children who do not eat well. BONADOXIN, for the prevention of nausea and vomiting of pregnancy and postoperatively. NEOBON, for the adult over 40. VI-THYRO, for the vitalized thyroid. ASF, an anti-stress formulation, and ROETINIC, the one-a-day capsule hematinic. Also on VITERRA, VITERRA THERAPEUTIC, Literature and clinic material will be available upon request.

### THE SANBORN COMPANY
**Booth 29**

Featured at the Sanborn Company booth will be a continuous demonstration of the new Sanborn Viso-Scope, a 5-inch cathode ray oscilloscope, specially designed for use with the Sanborn direct-writing electrocardiographs, such as the famous Viso-Cardiette — as well as with more elaborate recording systems used in the research laboratory.

The Viso-Cardiette itself will also be prominently displayed, as will the popular Sanborn Metalbulator. In addition full data will be available on Sanborn 1, 2, and 4-channel direct-writing recording systems: the Twin-Beam photographic recorder for simultaneous phonocardiography: the Electromanometer, for physiologic pressure measurements; and other Sanborn equipment for cardiovascular diagnosis and research.

### SANDOZ PHARMACEUTICALS
**Booth 4**

SANDOSTEN A new and powerful anti-permeability agent effective in the treatment of itching.

FIORINAL A new approach to therapy of tension headaches and other head pain due to sinusitis and myalgia.

CAFERGOT Available in oral and rectal form for effective control of head pain in migraine and other vascular headaches.

HYDERGINE A vasorelaxant with central and peripheral action useful in hypertension and peripheral vascular disorders and geriatric conditions.

### W. B. SAUNDERS COMPANY
**Booth 47**

Among the most practical books published in the last few months are: Current Therapy, 1956; Hinshaw & Garland: Diseases of the Chest; Sodeman: Pathologic Physiology, 2nd edition; Pillsbury et al: Dermatology; Laughlin: Neuroses in General Practice; Bland: Body Fluids, 2nd edition; Davis-Christopher: Testbook of Surgery, 6th edition; and Wolf: Electrocardiography.

These along with our standards such as: Cecil-Loeb: Medicine; Nelson: Pediatrics; Dorland: Dictionary; and the three Clinics of North America: Medical, Pediatric and Surgical, will be on display.

### SCHERING CORPORATION
**Booth 64**

A cordial invitation is extended to the members of the Illinois State Medical Society to visit the Schering exhibit. The entire exhibit will be devoted to METICORTEN and METICORTELONE, the new corticosteroids for the treatment of rheumatoid arthritis, intractable asthma and other so-called collagen diseases. Extensive clinical and laboratory data demonstrating certain advantages of these new steroids over cortisone and hydrocortisone are shown.

### JULIUS SCHMID, Inc.
**Booth 40**

An interesting and informative exhibit featuring RAMSES Flexible Cushioned Diaphragm; RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid, two new products embodying "Carlendacide", the recent development of Carl Henry Davis, M.D., and C. G. Grand for vaginal trichomoniasis therapy; and XXXX (Fourex) Skin Condoms, RAMSES and SHEIK Rubber Condoms for the control of trichomonal re-infection.

### G. D. SEARLE & COMPANY
**Booth 61**

You are cordially invited to visit the Searle Booth where our representatives will be happy to answer any question regarding Seale Products of research.

Featured will be Mictine, the new safe, nonmercurial oral diuretic; Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine and Pro-Banthine, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

## CHICAGO SEVEN-UP BOTTLING COMPANY
### Booth 1

The organizations that bottle and deliver sparkling, crystal-clear 7-Up to the people of Illinois will be represented at Booth 1.

They will be ready at all times to provide the cool, clean taste of 7-Up for thirsty conventioneers.

## SHARP & DOHME
### Booth 54

The Sharp & Dohme exhibit presents "Do-Deltra" and "Co-Hydeltra", specifically designed to provide all the benefits of prednisone and prednisolone plus positive antacid action to minimize gastric distress.

Related adrenal cortical steroid preparations in endocrine disorders, collagen diseases, respiratory allergies, eye diseases and skin conditions are also highlighted.

Expertly trained personnel will be pleased to discuss new dosage forms, new indications, and the latest summaries of advanced clinical reports in this field.

## SHERMAN LABORATORIES
### Booth 26

PROTAMIDE — A sterile colloidal solution of denatured proteolytic enzyme. Published clinical studies have convincingly established Protamide's value in neuritis, herpes zoster and other nerve root pains.

ELIXOPHYLLIN — Our newest product for reducing the frequency and severity of asthmatic attacks. Contains theophylline in complete hydro-alcoholic solution. It provides fast absorption of theophylline for higher blood levels — also an immediate effect on the threshold of the "alarm reaction" by virtue of its alcohol content.

## SMITH, KLINE & FRENCH LABORATORIES
### Booth 19

S.K.F. is glad to introduce its new product, "THORA-DEX" at this meeting. A combination of the tranquilizer "Thorazine" and the analeptic "Dexedrine" Sulfate, THORA-DEX is most useful in the control of symptoms of anxiety and depression which so often occur simultaneously in neuroses and psychoses. Come to the S.K.F. booth — We'll gladly tell you more about THORA-DEX.

## E. R. SQUIBB & SONS
### Booth 21

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the medical profession on new products or improvements on products already marketed.

At Booth 21 we are pleased to present up-to-date information on these advances for your consideration.

## THE UNITED STATES TOBACCO COMPANY
### Booth 35

The United States Tobacco Company will display its famous line of SANO tobacco products Sano cigarettes — both regular and King size Filter Tip; Sano All-Havana Cigars and Sano Pipe Tobacco — all with less than 1% nicotine by weight.

SANO meets the nicotine problem in the only effective way, by removing the nicotine from the tobacco, itself, before Sano tobacco products are made. SANO cigarettes, cigars and pipe tobacco for good sense and good taste.

## UNIVERSITY OF CHICAGO PRESS
### Booth 34

There will be an exhibit of medical books and general titles published by approximately 15 university presses throughout the country.

## THE UPJOHN COMPANY
### Booth 65

Members of the medical profession are invited to visit the Upjohn Booth where members of The Upjohn Company professional detail staff are prepared to discuss subjects of mutal interest.

## VITAMIN PRODUCTS COMPANY
### Booth 23

Manufacturers of Cytotrophic Extracts (Protomorphogens). A Protomorphogen is that component of the cell chromosome that is responsible for morphogenic determination of cell characteristics. It is the smallest unit of the cell blueprint assembly. It is the smallest unit of the gene system that guides the cell into its hereditary form as it grows, develops or repairs itself. Without sufficient protomorphogen in its chromatin, the cell degenerates, de-differentiates, becomes senile and dies.

## WINTHROP LABORATORIES, Inc.
### Booth 5

ALEVAIRE: Nontoxic inhalant which thins sticky pulmonary secretions in bronchitis, bronchiectasis, and neo-natal asphyxia.

HYPAQUE: Sodium 50% sterile solution (ampuls of 30cc) new well tolerated highly radiopaque medium for excretion urography, contains 59.87% iodine. Produces excretory urograms of a clarity approaching that usually obtained by the retrograde method.

## THE ZEMMER COMPANY
### Booth 30

We cordially invite the members of the Illinois State Medical Society to visit our exhibit. Our representatives, Milton Carrier and Robert Ehlers, will be in attendance to serve you.

# Committees

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Eugene T. McEnery, Chicago
Charles Allison, Kankakee
Paul S. Baur, Cairo
F. E. Bihss, East St. Louis
Geo. B. Callahan, Waukegan
Warren W. Furey, Chicago
Percy E. Hopkins, Chicago
John W. Little, Decatur
Karl A. Meyer, Chicago
G. Henry Mundt, Chicago
Charles H. Phifer, Chicago
H. Kenneth Scatliff, Chicago
Charles G. Stoll, Lawrenceville
J. S. Templeton, Pinckneyville
Arkell M. Vaughn, Chicago
Walter Whitaker, Quincy
Irving H. Neece, Decatur
Murray E. Rolens, Springfield
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Leo P. A. Sweeney, Chicago
Neill A. Thompson, Eldorado
Edward H. Weld, Rockford
C. Paul White, Kewanee

## TECHNICAL EXHIBITS COMMITTEE

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Vice-Chairman ..... Harold Swanberg, Quincy

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J. J. Grandone, Gillespie
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Michael A. Rydelski, Chicago
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Vice Chairman ..... John O. Firth, Monmouth

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Exofficio: Edward A. Uzemack
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Vice Chairman .. Elmer V. McCarthy, Chicago

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E. A. Veach, Vienna
H. L. Wallin, Chicago
Anders J. Weigen, Chicago
A. E. Westerdahl, Oak Park
John R. Wolff, Chicago

## LIAISON COMMITTEE WOMAN'S AUXILIARY BUFFET SUPPER AND PROGRAM

Tuesday night
May 15, 1956

Chairman .... Frederic M. Nicholson, Chicago

William E. Adams, Chicago
A. L. Burdick, Chicago
Ralph E. Dolkart, Chicago
John C. Dwyer, Harvey
Casper M. Epsteen, Chicago
Wayne W. Flora, Chicago
William Hartrick, Newton
Warren C. Blim, Chicago Heights
J. R. Burnett, Effingham
G. J. A. Dundon, Columbia
James C. Ellis, DeKalk
J. P. FitzGibbons, Chicago
David B. Freeman, Moline
Francis J. Hultgen, Evergreen Park
William A. Hutchison Chicago
R. F. Jordan, Pekin
Michael J. Kutza, Chicago
A. J. Linowiecki, Chicago
E. F. Keckermann, Elmhurst
Lawrence Ryan, Chicago
Noel Shaw, Evanston
George C. Turner, Chicago
Adrien Verbrugghen, Chicago
James W. West, Chicago
Garvies R. Johnson, Harrisburg
L. J. Jurek, Chicago
James Langstaff, Fairbury
Robert R. Mustell, Chicago
Joseph A. Patka, Chicago
Charles Sandberg, Homewood
L. S. Tichy, Chicago
Karl L. Vehe, Chicago
Earl F. Walker, Roodhouse
F. W. Young, Chicago

## WOMEN PHYSICIANS' BREAKFAST COMMITTEE

Chairman ..... Elizabeth R. Fischer, Chicago
Clementine E. Frankowski, Rose V. Menendian, Elizabeth A. McGrew, Lily Rappolt.

## SPECIAL COMMITTEE TO RECEIVE AND ENTERTAIN GUEST SPEAKERS

Section on Allergy:
Guest: Vincent Derbes from New Orleans
Host: MILTON M. MOSKOW, Chairman of the Section on Allergy, Chicago

Section on Anesthesiology:
Guest: Harvey C. Slocum, Washington, D.C.
Host: ARTHUR T. SHIMA, Chairman of the Section, Oak Park

Section on Cardiovascular Disease
Guest: E. Grey Dimond, Kansas City, Kansas
Host: CHAUNCEY C. MAHER, Chairman of the Section, Chicago

Section on Dermatology:
Guest: John H. Lamb, Oklahoma City
Host: JAMES HERBERT MITCHELL, Chairman of the Section Chicago
BENJAMIN Z. RAPPAPORT, Chicago
ADOLPH ROSTENBERG, Jr., Chicago

Section on Eye, Ear, Nose and Throat
Guest: Henry P. Wagener, Rochester, Minnesota
Host: FLETCHER AUSTIN, Chairman of the Section, Chicago

Section on Obstetrics & Gynecology
Guest: John C. Ullery, Columbus, Ohio
Host: CHARLES D. KRAUSE, Chairman of the Section, Chicago
HUBERT L. ALLEN, Alton
EDWIN J. DeCOSTA, Chicago

Section on Pediatrics
Guest: Robert Goode, Minneapolis, Minnesota
Host: J. KELLER MACK, Chairman of the Section, Springfield
Section on Public Health and Preventive Medicine
Guest: Edward Krumbiegel, Milwaukee, Wisconsin
Host: FRED LONG, Chairman of the Section, Peoria
Section on Radiology
Guest: Chester H. Warfield, Fort Wayne, Indiana
Host: FRED H. DECKER, Chairman of the Section, Peoria
IRVIN HUMMON, Jr., Chicago
GEORGE M. LANDAU, Chicago
Section on Surgery:
Guest: Charles G. Johnston, Detroit, Michigan
Host: CORNELIUS M. ANNAN, Chairman of the Section, Chicago
ARKELL M. VAUGHN Chicago, and EVERETT P. COLEMAN, Canton
The Two Orators
(1) In Medicine: Charles H. Rammelkamp, Cleveland, Ohio, Guest of the President: F. Garm Norbury, Jacksonville
(2) In Surgery: Brown M. Dobyns, Cleveland, Ohio, Guest of the President: F. Garm Norbury, Jacksonville

# PROGRAM
# of the
# TWENTY-EIGHTH ANNUAL MEETING
# of the
# WOMAN'S AUXILIARY
# ILLINOIS STATE MEDICAL SOCIETY
# May 14, 15, 16, 17, 1956
## HOTEL SHERMAN Chicago

A most cordial invitation is extended to all members of the Woman's Auxiliary to the Illinois State Medical Society, and to the wives and guests of physicians attending the meeting of the Illinois State Medical Society, to participate in all social functions and attend the general sessions of the Auxiliary.

Headquarters will be at the Hotel Sherman. Tickets may be secured at the registration desk during the convention, or through your County, or by writing the ticket chairman, Mrs. J. L. Marks, 554 West 107th Street, Chicago, Illinois direct, in advance of the meeting.

Please register when you arrive and obtain your badge and program.

### PRE-CONVENTION SCHEDULE

Monday, May 14, 1956

3:00 p.m. to 5:00 p.m.
Registration, Hotel Sherman House on the Roof Solarium

1:30 p.m.
Pre-Convention Board Meeting, House on the Roof Solarium

### CONVENTION PROGRAM

Tuesday, May 15, 1956

8:30 a.m. to 4:00 p.m.
Registration, Lobby, Hotel Sherman

9:00 a.m.
Formal Opening of the Twenty-Eighth Annual Meeting of the Woman's Auxiliary to the Illinois State Medical Society.

FIRST SESSION — House of Delegates, House on the Roof

Presiding Officer ..... Mrs. Warren Young, President
Invocation ..... Rev. Robert Dahl, Chaplain Wesley Memorial Hospital, Chicago
Pledge to the Flag .... Mrs. G. Henry Mundt
Auxiliary Pledge .... Mrs. James P. Simonds
Welcome ..... Mrs. Matthew Uznanski
Response ..... Mrs. N. D. Crawford

BUSINESS SESSION

Credentials and Registration ..... Mrs. Fernly Johnson

Convention Rules of Order Mrs. Glenn Suthers
Adoption of Convention Program
Appointment of Reference Committees
Appointment of Reading Committees
Appointment of Committee on Courtesy and Resolutions
Coffee Break
President's Reports
..... Mrs. E. H. Leveroos

12:00 noon

LUNCHEON honoring Past Presidents
Guest Speaker ..... The Hon. Everett M. Dirkson, United States Senator from Illinois
Luncheon Chairman .....
Mrs. Albert Kwedar Immediate Past President
Co-Chairman ..... Mrs. Henry F. Berchtold

REFERENCE COMMITTEE MEETINGS
General Reference Chairman . Mrs. Lee Hamm

3:00 p.m.
Reports of Officers and Directors

3:30 p.m.
Reports of Standing Committees

4:00 p.m.
Reports of Councilors
Guests are welcome at all Reference Committee meetings

9:00 p.m.

BUFFET SUPPER
Chairman ..... Mrs. N. G. Chester

Wednesday, May 16, 1956

8:30 a.m. to 4:00 p.m.
Registration Lobby, Hotel Sherman

9:00 a.m.

SECOND SESSION — House of Delegates .... House on the Roof
Presiding Officer .....
..... Mrs. Warren Young, President
Credentials and Registration .....
..... Mrs. Fernly Johnson
Introduction of Program .....
..... Mrs. Nicholas G. Chester

"LEADERSHIP CLINIC"
Presented by .... Dr. Martin P. Chworowsky

10:30 a.m. to 10:40 a.m.
Coffee break
"Leadership Clinic" — continued
Convention Announcements .....
..... Mrs. E. H. Leveroos

12:00 noon to 12:30 p.m.
Reference Committee Summaries .... House on the Roof

1:00 p.m.
Luncheon and Fashion Show ..... Wedgewood Room Marshall Field & Company
Luncheon Chairman ..... Mrs. J. S. Lundholm, Councilor First Councilor District

7:00 p.m.

ANNUAL DINNER honoring Dr. F. Garm Norbury, Retiring President Illinois State Medical Society
Guest Speaker ..... Dr. Elmer Hess, President, American Medical Association

Thursday, May 17, 1956

9:00 a.m.
THIRD SESSION — House of Delegates, Ballroom
Presiding Officer .....
..... Mrs. Warren Young, President
Credentials and Registration .....
..... Mrs. Fernly Johnson
Courtesy and Resolutions .. Mrs. E. M. Egan
Report of Nominating Committee .....
..... Mrs. Henry Christiansen
Election of Officers
Unfinished Business
New Business

11:30 a.m.
Memorial Service
Conducted by .... Mrs. Oliver E. Veneklasen
Organ music by Mr. Don De Vale

1:00 p.m.
LUNCHEON honoring Mrs. Warren Young, President ..... Assembly Room
...Mrs. Robert E. Dunlevy, President-Elect
Program by .....
....Mrs. Lillian Brodahl Smith, Dramatist
Installation of Officers .. Mrs. Harlan English
Luncheon Chairman ..... Mrs. L. J. Houda
Co-Chairman ..... Mrs. Matthew Uznanski
Organ music by Mr. Don De Vale

3:30 p.m. House on the Roof
Post Convention Board Meeting
Presiding Officer ... Mrs. Robert E. Dunlevy

## CONVENTION COMMITTEES

CONVENTION CHAIRMAN .....
..... Mrs. E. H. Leveroos
CO-CHAIRMAN ..... Mrs. B. K. Lazarski

PRESS AND PUBLICITY
Chairman ..... Mrs. G. T. Buttice
Co-Chairman ..... Mrs. Carl Sibilsky

REGISTRATION AND CREDENTIALS
Chairman ..... Mrs. Fernly Johnson
Co-Chairman ..... Mrs. John Keehan
Mrs. Gregory Cary, Advisor

Mrs. W. W. Armstrong
Mrs. Carl David
Mrs. Silvio DelChicia
Mrs. Charles Noggle
Mrs. O. T. Roberg, Jr.
Mrs. J. S. Schriver
Mrs. Fred L. Sheehan
Mrs. K. L. Vehe
Mrs. R. E. Westland
Mrs. Erick Larsen
Mrs. Arthur Chalonpka
Mrs. C. D. Brown
Mrs. E. C. Helfers
Mrs. Clarence Norberg
Mrs. Gordon L. Rosene
Mrs. Joseph Shanks
Mrs. Roy T. Sugars
Mrs. A. J. Weigen
Mrs. C. Wynekoop

COURTESY AND RESOLUTION
Chairman ..... Mrs. E. M. Egan
Mrs. J. P. Simonds — Mrs. W. J. Wanninger

TIME KEEPERS
Chairman ..... Mrs. Frank J. Wall, Jr.
Mrs. W. Borkenhagen — Mrs. M. M. Friedell
Mrs. Herbert Loseff — Mrs. M. Farinacci
Mrs. F. L. Glenn

MEMORIAL SERVICE
Chairman ..... Mrs. Oliver E. Veneklasen

HOSPITALITY
Chairman ..... Mrs. J. M. McDonnough
Co-Chairman ..... Mrs. Henry Christiansen
Mrs. E. M. Egan — Mrs. W. J. Wanninger
Mrs. V. E. Engelmann — Mrs. R. V. Grimmer
Mrs. Loring Helfrich — Mrs. Joseph T. O'Neill
Mrs. C. Paul White — Mrs. Marlin Woloski

INFORMATION
Chairman ..... Mrs. William H. Pfisterer
Mrs. Leonard Brodt — Mrs. Charles Corcoran
Mrs. V. A. Avakian — Mrs. Garland Brown
Mrs. M. Farinacci — Mrs. D. D. Jamison
Mrs. Robert E. Lee — Mrs. Stanley E. Ruzich
Mrs. John Soukup — Mrs. Charles S. Vil

FLOWERS
Chairman ..... Mrs. Henry L. Schmitz

PAGES
Chairman ..... Mrs. Armand J. Mauzey
Co-Chairman ..... Mrs. Allen S. Watson
Mrs. Chester Black — Mrs. Charles Gutzmer
Mrs. R. W. Elworthy — Mrs. Glenn L. Judson

REFERENCE
General Chairman ..... Mrs. Lee Hamm
Chm., Committee I .... Mrs. Darrell Trumpe
Chm., Committee II ..... Mrs. Leo Grezch
Chm., Committee III .. Mrs. J. Van Prohaska

TICKETS
Chairman ..... Mrs. J. L. Marks
Co-Chairman ..... Mrs. V. E. Engelmann
Mrs. M. J. Brosnan — Mrs. Christian Meyer
Mrs. Fred L. Glenn — Mrs. E. G. Warnick
Mrs. H. Sehneider — Mrs. R. Field

INSTALLATION OF OFFICERS .....
..... Mrs. Harlan English

PAST PRESIDENTS' LUNCHEON, Tuesday, May 15
Chairman ..... Mrs. Albert Kwedar
Co-Chairman ..... Mrs. Henry Berchtold
Mrs. N. C. Meyer
Mrs. D. H. Trumpe
Mrs. Jacob E. Reisch

LUNCHEON AND FASHION SHOW, Wednesday, May 16
Chairman ..... Mrs. J. S. Lundholm
Mrs. Charles Lesage — Mrs. Lewis A. Hare
Mrs. H. C. Hesseltine — Mrs. H. K. Scatliff
Mrs. F. E. Bollaert — Mrs. Daniel Raber
Mrs. G. Vernon — Mrs. H. Schoonover
Mrs. W. F. Lantz — Mrs. D. A. Lehman
Mrs. G. H. Edwards — Mrs. C. S. Leimbacher

PRESIDENT'S LUNCHEON, Thursday, May 17
Chairman ..... Mrs. L. J. Houda
Co-Chairman ..... Mrs. Matthew Uznanski
Mrs. A. Schultz — Mrs. A. M. Barone
Mrs. J. P. Cangelosi — Mrs. N. Earl Landy
Mrs. S. A. Lask — Mrs. N. A. Klucikowski
Mrs. Nicholas Mennite — Mrs. G. L. Pastnack
Mrs. T. S. Proud — Mrs. G. W. Scupham
Mrs. I. D. Thrasher — Mrs. Frank Wall, Jr.

HOUSE CHAIRMAN ... Mrs. B. K. Lazarski

***— and then there are the theatres, the shops, the new restaurants!***

# THE P. R. PAGE



**Credit to man on strike**

There are not too many labor disputes these days, but some which do occur are of long standing. As a result, many workers not only soon reach the end of their savings but go into debt. When sickness strikes the family, the situation is aggravated.

Most physicians are anxious to retain the usual fine relationship with their patients and when approached for medical care under such circumstances they can do the profession a service by agreeing to deferred payments in most instances.

Some people may argue that this is contributing to the extension of a strike. This is not true. After a strike has been called, the rank and file in a union seldom has a chance to vote for its ending until the leaders are good and ready. These leaders do not feel the pinch of the dispute and so far as they are concerned the strike can go on indefinitely.

The workman out of work has nothing to say, nor can he go back to his old job even if he was satisfied in the first place.

The Philadelphia County Medical Society recently had a conference with AFL-CIO officials on this point, particularly as it related to the Westinghouse Electric strike, and assured the unions that doctors will cooperate with those in need.

Perhaps a physician who renders service irrespective of present ability to pay will end up with some uncollectible accounts, but he also will make many friends. The profession can't have too many.

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**Study of newspaper medical coverage**

Every physician interested in public relations should read the two-part study of newspaper medical coverage which appeared in the Journal of the American Medical Association recently.

The author, Dr. Harry A. Wilmer, assistant clinical professor psychiatry at Stanford University, San Francisco, studied 1,260 newspaper clippings from 89 newspapers in the San Francisco area during a seven-month period.

His summary and conclusions are:

"A review of the problems of medical ethics in relationship to newspaper publicity shows that there is more need for clarification of the interpretation of medical ethics for the average physician than there is for drastic revision of the code. The provisions concerning his cooperation with the press and the use of his name allow for greater participation with the press in public education than is generally realized in print.

"There is a need for active public relations committees within the medical societies to stimulate and work with reporters on news stories. Local societies should adopt codes of press rela-

[1]Wilmer, H. A.; Facts and Feelings about Newspaper Medical Coverage, J.A.M.A. 160: 663-668 (Feb. 25) 1956, and 160: 768-774 (Mar. 3) 1956.

tionship in mutual consultation with local press representatives.

"The provisions concerning advertising are most notably difficult to interpret. In the 1,260 articles studied, the medical profession and the press conducted themselves for the most part with wisdom. As a consequence, the public was given fair coverage of medical news. When a medical society engages in advertising in highly controversial matters it may suffer more than it gains. How far reasoning on this can be extended (as, for example, in the fight against socialized medicine) is not considered in this study.

"There is an increasingly warm relationship between medicine and the press, and much of the credit would seem to go to the press and public relations departments of the American Medical Association and also the National Association of Science Writers. There were relatively few sensational features and stories and relatively few questionable articles.

"If one could make a subjective generalization on these data it would be that medical public relations are as good or as bad as the efforts, attitudes, anxieties, and statements of physicians. Medical writing was in general of a high order. In the San Francisco area and at the present time, the press is an ally of the ethical physician. There is need, however, for each better to understand the specific problems of the other.

"If medical public relations committees would present cogent criticisms to editors on specific questionable articles at the time questionable stories appear, they might diminish the quantity and improve the quality. If the medical societies would at the same time constructively help the press in finding and writing new articles and cooperate with procurement of authoritative statements that are not anonymous, their criticisms would fall upon more receptive ears."

While Dr. Wilmer's study covers a Pacific Coast area, the problems and the experiences have counterparts in Illinois and for that matter everywhere else.

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## Pregnancy during lactation

Although the common belief that pregnancy is unlikely to occur in lactating women appears to be well founded, it has not been easy to obtain reliable information about its frequency. There are two sources of difficulty; the proportion of women who feed their children for long periods is not high; and the use of other contraceptive measures makes it impossible to regard lactation as the only reason for the inhibition of conception. In a recent investigation by R. Gioiosa of the histories of 500 mothers in a Catholic hospital in the United States, these difficulties were largely avoided. Most of the women fed their children for many months, and the fact that a high proportion of those who were not pregnant at the end of lactation conceived soon after (more than half within four months and three-quarters within nine months) suggests that no other form of contraceptive was in common use. Forty-six of the 500 mothers, about one in 10, became pregnant while they were still lactating. In most of these cases, conception occurred after many months of breast feeding when weaning had begun; there were no conceptions in the first three months, and only seven in the first six months. *Conception during Lactation. Brit. M.J. Dec.* 31, 1955.

# CORRESPONDENCE



## Chicago doctors on program of Int'l. Academy of Proctology

Chicago physicians will play an important role in the scientific program of the Eighth Annual Convention of the International Academy of Proctology at the Drake Hotel, Chicago, April 23-26, according to Dr. Caesar Portes, chairman of the program committee.

The convention will be opened with greetings by Dr. F. Lee Stone of Chicago, president-elect of the Illinois State Medical Society. The scientific presentation will consist of papers, panel, symposia and motion pictures.

Among the subjects will be ulcerative colitis, carcinoma of the rectum and colon, hemorrhoids, ano-rectal strictures, pilonidal cysts, surgical complications of ano-rectal surgery, polyps, amebiasis, diverticulitis, fluids and electrolytes in gastro-intestinal surgery, anesthesia and many other related diseases.

The Chicago physicians who will participate in the scientific program are: Drs. Joseph B. Kirsner, Manuel B. Lichtenstein, George J. Rukstinat, George Schropshear, Walter C. Bornemeier, Harry A. Gussin, Sid J. Shafer, John R. Wolff, Roland R. Cross, Max S. Sadove, Leon Aries, Karl A. Meyer, Earle I. Greene, William H. Shlaes, James D. Majarakis, Arkell M. Vaughn, Harry F. Weisberg, Edward J. Krol, Manuel G. Spiesman, Caesar Portes, and Edward Kowalski.

Dr. Louis S. Wegryn of Elizabeth, N.J., president of the Academy, will give his address at the opening session. Dr. Manuel Spiesman of Chicago will succeed him as president.

## Illinois doctors on Int'l. College of Surgeons Program

Illinois surgeons will be among the speakers on the program of the Great Lakes Division regional meeting of the United States Section, International College of Surgeons, at the Loraine Hotel, Madison, Wis., April 26-28.

With regents of 13 states invited to participate, the meeting is expected to be the largest regional conference ever held by the College, according to Dr. Arnold S. Jackson of Madison, president of the United States Section.

The scientific program on the second and third days will consist of nine panel discussions and the presentation of 13 papers.

Dr. Louis P. River of Oak Park will speak on "Surgical Treatment of Breast Carcinoma;" Dr. Chester B. Guy of Chicago on "The Use of Tantalum Mesh in Herniorrhaphy," and Dr. Alfred A. Strauss of Chicago on "Plastic Surgical Repair of Urethral Stricture."

There will be panels on "The Acute Surgical Abdomen," "Gastrointestinal Hemorrhage," "Biliary Surgery," "Problems of Thyroid Surgery," "Problems of Herniorrhaphy," "Colon Surgery Problems," "Urolithiasis," "Surgical Problems in Gastro-Duodenal Ulcer" and "The Management of Hip Fractures."

Illinois surgeons who will participate in these panels will be: Drs. Walter C. Bornemeier, Edward L. Compere, Manuel E. Lichtenstein, Raymond W. McNealy, Karl A. Meyer, Harry A. Oberhelman, Peter A. Rosi, Carlo S. Scuderi, Lindon Seed, James E. Seagraves, Arkell M. Vaughn and Leo M. Zimmerman of Chicago;

George Callahan of Waukegan; and Everett P. Coleman of Canton.

Dr. Ross T. McIntire of Chicago, executive director of the International College of Surgeons, at an informal dinner on the evening of the opening day, will relate some of his interesting life experiences. Dr. Callahan will present an illustrated talk on the Far East.

A banquet will be held on the evening of the second day. An entertainment program has been provided for wives.

## Illinois Surgical Society to hold operative clinics

The Illinois Surgical Society will sponsor a clinical and scientific program, May 14. Operative clinics will be held during the day in the Cook County Hospital, Chicago. In the evening, there will be a scientific meeting in the University Club.

The operative clinics and the participants in the program are:

Surgery of the Common Duct—Manuel E. Lichtenstein; discussion by Lichtenstein, Everett P. Coleman and Chester C. Guy.

Colon Surgery—(panel) Kenneth R. Gilchrist, Peter Rosi, Kenneth H. Schnepp and Louis River.

Repair of Recurrent Hernia—Harry Oberhelman.

Production and Treatment of Cardiac Arrest—(demonstration) Egbert Fell.

Management of the Severely Burned Patient—(demonstration) John L. Bell; discussion by Capt. H. H. Eighmy, U.S.N.

Fractures, Orthopedic, Trauma—Carlo S. Scuderi.

Diseases of the Thoracic Cavity—George Holmes.

Gastrectomy—Samuel J. Fogelson.

Vagotomy—Arkell M. Vaughn.

Hemicolectomy—John B. O'Donoghue.

Colectomy—Francis Straus.

Use of Radioactive Material for Diagnosis and Treatment—Morris P. Friedell.

Thyroidectomy—Leon Aries; discussion by Howard P. Sloan.

Arterial Transplant for Femoral Obstruction—Richard Lawler.

Lumbar Sympathectomy—William M. McMillan.

Neurosurgery—Milton Tinsley.

There will be a dinner for members and guests in the evening. Following this, scientific program will be presented, consisting of:

Persistent Symptoms Following Cholecystectomy—Waltman Walters; discussion by Charles Peustow, Raymond McNealy and Peter Rosi.

Duodenal Ulcer—Hypothalmus, Pituitary, Adrenal Axis—Lester Dragsted; discussion by Karl A. Meyer and Kennedy R. Gilchrist.

Thoracic Surgery by the General Surgeon—Jerome Head; discussion by George Holmes and Robert De Bord.

All members of the medical profession are invited to attend the operative clinics and the evening scientific session.

## Attention ladies!

We are planning on you! We are planning for you! The 1956 Convention of the Woman's Auxiliary to the Illinois State Medical Society at the SHERMAN HOTEL, MAY 15th, 16th, & 17th.

**BUSINESS**

With you in mind, our program is designed for business—of interest to us all. It will be streamlined for efficiency and transacted with dispatch.

**EDUCATION**

With you in mind, our program is designed for education—Dr. Martin P. Chworowsky, Director of the Human Relations Clinic of the University of Pennsylvania, will again be with us by popular request. You won't want to miss this interesting, informative speaker. We are indeed fortunate to have the Honorable Senator Everett M. Dirksen on our program. The Senator is a dymanic speaker exceedingly well qualified to address us on matters of legislation.

**PLEASURE**

With you in mind, our program is designed for pleasure—You will be delighted with the rollicking humor of Mrs. Lillian Brodahl Smith, well known in the mid-west for her special brand of comedy.

**ADDED ATTRACTIONS**

We are planning three outstanding luncheons. One, to honor our Councilors, will be held at



Convention Chairmen and officers of the 28th Annual Convention of the Woman's Auxiliary to the Illinois State Medical Society, May 15, 16, 17, 18, 1956, Hotel Sherman: Left to right, sitting: Mrs. Henry L. Schmitz, Flower Committee; Mrs. E. H. Leveroos, Convention; Mrs. Warren W. Young, Auxiliary President. Left to right, standing: Mrs. James M. McDonnough, Hospitality; Mrs. J. S. Lundholm, Councilors' Luncheon; Mrs. G. T. Buttice, Publicity; Mrs. Edward G. Warnick, State Treasurer; Mrs. Fernly Johnson, Credentials and Registration; Mrs. William H. Pfisterer, Information.

Marshall Fields and will feature a lovely spring style show. Another will honor our Past Presidents and the third will honor our President.

Our Hospitality Committee will be working overtime to make sure you will enjoy yourself.

This is your convention so do come and we shall all work, learn and laugh together.

PATRICIA LEVEROOS, (Mrs. E. H.)
Convention Chairman

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## Clinics for crippled children listed for May

Twenty five clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois Division of Services for Crippled Children. The Division will count 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The May clinics are:

May 1—Macomb, Marietta Phelps Hospital
May 1—Fairfield, Fairfield Memorial
May 2—Hinsdale, Hinsdale Sanitarium
May 2—Pittsfield, Illini Hospital
May 3—DuQuoin, Marshall-Browning Hospital
May 3—Monticello, Lincoln School
May 3—Sterling, Field House
May 8—Casey, Casey High School
May 8—E. St. Louis, St. Mary's Hospital
May 8—Peoria, Children's Hospital
May 9—Joliet, Will County T.B. Sanitarium
May 10—Elmhurst Cardiac, Memorial Hospital of DuPage County
May 10—Springfield, St. John's Hospital

May 11—Chicago Heights Cardiac, St. James Hospital
May 15—Alton, Alton Memorial Hospital
May 16—Evergreen Park, Little Company of Mary Hospital
May 17—Rockford, St. Anthony's Hospital
May 18—Evanston, St. Francis Hospital
May 22—Peoria, Children's Hospital
May 23—Aurora, Copley Memorial Hospital
May 23—Springfield (Cerebral Palsy), Memorial Hospital
May 24—Litchfield, Madison Park School
May 24—Bloomington, St. Joseph's Hospital
May 25—Chicago Heights Cardiac, St. James Hospital
May 29—Effingham (Rheumatic Fever), St. Anthony's Hospital

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## Annual meeting Illinois Society of Anesthesiologists

May 13, 1956
Hotel Sherman, Chicago.

9:00 AM Registration
10:00 AM to 12:15 PM Scientific Program.

"Office Anesthesia" — Hugh O. Brown, M.D., Salt Lake City, Utah. President, Utah Society of Anesthesiologists.

"Management of Anesthesia in Patients with Pulmonary Emphysema," Karl L. Siebecker, M.D., Madison, Wisconsin. Asst. Professor of Anesthesiology, University of Wisconsin.

"Fundamental Pharmacology in Relation to Anesthesia", John Adriani, M.D., Director, Dept. of Anesthesia, Charity Hospital, New Orleans, La.

"Post-Operative Vomiting, Fact and Fancy," — Edward Mayer, M.D., St. Francis Hospital, Evanston, Ill.

12:30 PM Round Table Luncheon.

2:00 PM "(title to be announced)" — Harvey C. Slocum, Col., M.C., Consultant in Anesthesiology, Dept. of the Army, Office of the Surgeon General. Business meeting and election of officers to follow scientific program.

## Chest physicians to meet

The 22nd Annual Meeting of the American College of Chest Physicians will be held at the Hotel Sherman, Chicago, June 6 through 10, 1956. The scientific program will include prominent speakers on all aspects of heart and lung diseases. In addition to formal presentations, there will be a number of symposia, round table luncheon discussions, seminars, and motion pictures.

The Fireside Conferences, which were inaugurated at the annual meeting of the College in 1955 and proved to be so popular, will be repeated. At this session, more than 50 experts will be present to lead the discussions on many subjects of current interest in the specialty of diseases of the chest.

Examinations for Fellowship in the College will be held on Thursday, June 7. On Saturday evening, June 9, more than 150 physicians will receive their certificates of Fellowship at the annual Convocation, which will precede the Presidents' Banquet.

All interested physicians are cordially invited to attend the 22nd Annual Meeting of the College; there is no registration fee. Copies of the program may be obtained by writing to the Executive Offices, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

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## American Goiter Ass'n. meets in Chicago

This is the preliminary program of the American Goiter Association, to be held at the Drake Hotel, Chicago, Illinois
May 3, 4 and 5, 1956.

THURSDAY MORNING, MAY 3, 1956
8:30 - 12:00

1. The Biological Activity of Pork and Beef Thyroid Preparations.
   N. R. Stasilli and R. L. Kroc, Morris Plains, New Jersey.
2. Metabolic Actions of Thyroxine Derivatives and Analogs.
   S. B. Barker, Birmingham, Alabama.
3. Additive Effects of Phosphate and Triiodothyronine in Dogs.
   K. E. Roberts, G. Firmat, P. Vanamee, J. W. Poppell and R. W. Rawson, New York, New York.

4. Effect of Estrogen on Thyroid Function.
   J. Feldman, Pittsburgh, Pennsylvania
5. Alterations in Chick Thyroid Function Induced by Cobalt.
   J. P. Kriss, F. S. Greenspan and W. H. Carnes, San Francisco, California.
6. Factors Governing the Development of the Chick Embryo Thyroid. IV. The Influence of Vitamin B-12 Deficiency on the Uptake of $I^{131}$, the Formation of Iodinated Compounds, and Histologic Structure of Glands from Adult and Embryonic Chickens.
   T. M. Ferguson, J. B. Trunnell, Jr. R. Couch, B. Dennis and P. Wade, Houston, Texas.
7. Perchlorate and the Metabolism of Radioiodine in Propylithiouracil-Treated Rats.
   N. S. Halmi and R. G. Stuelke, Iowa City, Iowa.
8. Loss of Appetite for Alcohol and Alcoholic Beverages Produced in Rats by Treatment with Thyroid Preparations.
   C. P. Richter, Baltimore, Maryland.

THURSDAY AFTERNOON, MAY 3, 1956
2:00 - 5:30

9. Effects of Organic Iodine Compounds on Iodine Metabolism.
   D. W. Slingerland, Boston, Massachusetts.
10. The Diagnostic Use of New in Vitro Tests of Thyroid Function.
    M. W. Hamolsky and A. S. Freedberg, Boston, Massachusetts.
11. Thyroid Function Studies in Children Using Radioactive Iodine.
    R. M. Kohlenbrener, R. H. Kunstadter, T. Fields, L. Oliner and with Technical Assistance of D. R. Goldstein, Chicago, Illinois.
12. Thyroxine-Binding by Sera of Pregnant Women.
    J. T. Dowling, N. Freinkel and S. H. Ingbar, Boston, Massachusetts.
13. Radiothyroxine Turnover Studies in Myxedema, Thyrotoxicosis, and Hypermetabolism Without Endocrine Disease.
    K. Sterling and R. B. Chodos, Syracuse, New York.
14. Metabolic Studies of Protein Metabolism in Patients with Myxedema Before and After Treatment with L-Triiodothyronine.
    K. R. Crispell, G. A. Williams, W. Parson and G. Hollifield, Charlottesville, Virginia.
15. Comparison of Thyroid Iodine 131 Uptakes of Treatment Versus Tracer Doses.
    R. Gorson, R. Chamberlain and E. Rose, Philadelphia, Penn.
16. Rise in Basal Metabolic Rate and Fall in Protein Bound Iodine Induced by Epinephrine.
    D. R. Korst, N. S. Hiramoto and W. H. Beierwaltes, Ann Arbor, Michigan.

FRIDAY MORNING, MAY 4, 1956
8:30 - 12:00

17. Van Meter Prize Essay
18. New Laboratory Aids in the Diagnosis of Hyperparathyroidism.
    E. L. Chambers, Jr., G. S. Gordan, L. Goldman and E. C. Reifenstein, Jr., San Francisco, California, and E. R. Squibb & Sons, New York, New York.
19. The Physiologic Activity of Triiodo — and Tetraiodothyroacetic Acid in Human Myxedema
    J. Lerman and R. Pitt-Rivers, Boston, Massachusetts.
20. An Attempt at a Physiological Classification of Cretinism.
    J. B. Stanbury and A. Querido, Boston, Massachusetts.
21. Inhibition of $I^{131}$ Uptake by L-Triiodothyronine in Euthroid Persons and Patients with Exophthalmic Goiter.
    W. M. Mcconahey and C. A. Owen, Jr., Rochester, Minnesota.
22. The Significance of Low Thyroid Reserve.
    W. MCK. Jefferies, L. W. Kelly, Jr., R. P. Levy, G. W. Cooper and R. L. Prouty, Cleveland, Ohio
23. Some Observations on Acute Thyroiditis.
    P. G. Skillern, H. E. Nelson and G. Crile, Jr., Cleveland, Ohio.

FRIDAY AFTERNOON, MAY 4, 1956
2:00 - 5:00

24. Presidential Address: The Thyroidologist and Beckoning Frontiers.
    R. Rawson, New York, New York.
25. Lymphosarcoma and Small-Cell Carcinoma of the Thyroid Gland.
    A. J. Walt, L. B. Woolner and B. M. Black, Rochester, Minnesota.
26. Carcinoma of the Thyroid Gland. A Clinical

and Pathologic Study of 300 Patients.
S. Lindsay, J. Friedlander, M. E. Dailey and W. H. Rustad, San Francisco. California.

27. Hormonal Treatment of Carcinoma of the Thyroid.
C. G. Thomas, Jr., Chapel Hill, North Carolina.
28. A Clinico-Pathological Study of 262 Surgical Cases of So-Called "Thyroiditis"
V. K. Frantz and A. W. Harland, New York, New York.
29. Invasive Fibrous Thyroiditis (Riedel's Struma).
L. B. Woolner, W. M. Mcconahey and O. H. Beahrs, Rochester, Minnesota.
30. Serum "Thyroglobulin" in Hashimoto's Thyroiditis.
C. A. Owen, Jr., and W. M. Mcconahey, Rochester, Minnesota.

SATURDAY MORNING, MAY 5, 1956
8:30 - 12:30

31. Malignant Exophthalmos.
A. E. Braley, Iowa City, Iowa.
32. Levator Spasma a Factor in Exophthalmos and its Correction.
R. E. Moran, Washington, D. C.
33. Nodular Lesions of the Thyroid Gland in Children.
A. B. Hayles, R. L. J. Kennedy, L. B. Woolner and B. M. Black, Rochester, Minnesota.
34. Thyroid Cancer in Childhood and Adolescence.
J. Majarakis, D. Slaughter and W. H. Cole, Chicago, Ill.
35. The Thyroid Scintigram: An Evaluation of its Clinical Use.
A. Kugel, N. Specht, R. Adams and E. J. Boehme, Los Angeles, California.
36. The Selection of Patients for Thyroid Surgery.
J. M. Miller, M. A. Block and B. E. Brush, Detroit, Michigan.
37. Effect of Anesthesia and Thyroid Surgery on Serum Levels of Radioactive Protein Bound Iodine Levels.
J. D. Hydovitz, Philadelphia, Pennsylvania.
38. The Complications of Thyroid Surgery.
O. H. Beahrs and A. A. White, Rochester, Minnesota
39. A Study of One Thousand Cases of Thyroid Surgery. The Complications and Implications.
W. H. Cole, E. F. Fowler, Chicago, Ill.

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## Announce panel symposium

The Metropolitan Chicago Chapter of The American College of Surgeons Announces a Panel Symposium on "Cardiovascular-Renal Problems of the Injured" By Authorities in their medical fields who will sponsor their Residents at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago, Illinois on Thursday, May 24, 1956 at 8:00 P.M.

The moderator of symposium with questions and answer period to follow will be Dr. LeRoy H. Sloan, Clinical Professor of Medicine, University of Illinois, Chief of the Medical Service, Illinois Central Hospital, Editor-in-Chief, Tice-Sloan Practice of Medicine.

PROGRAM

1. "Preparation of the Cardiac patient for Surgery" Dr. Chauncey C. Maher.
2. "Anesthesia in injured Cardiacs" Dr. Max S. Sadove.
3. "Modern concepts in the management of Traumatic shock" Dr. J. Garrott Allen.
4. "Management of the injured Kidney" Dr. William J. Baker and Dr. Robert McKendry, Senior Resident Cook County Hospital.

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## Pediatric courses at Children's Hospital, Philadelphia

The following short courses will be conducted at The Children's Hospital of Philadelphia in May and June 1956.

1. PEDIATRIC ADVANCES FOR PEDIATRICIANS AND GENERAL PRACTITIONERS. May 28 through June 1, 1956. A Refresher Course conducted by the Staff of the Children's Hospital of Philadelphia, in collaboration with the Department of Pediatrics of the University of Pennsylvania and the Camden Municipal Hospital. Tuition — $100.00

2. PRACTICAL PEDIATRIC HEMATOLOGY. June 4, 5 and 6. Conducted by Dr. Irving J. Wolman and other members of the Hematology Department of the Children's Hospital, under the auspices of the Graduate School of Medicine, University of Pennsylvania. Tuition — $60.00.

3. BLOOD GROUP INCOMPATIBILITIES AND ERYTHROBLASTOSIS FETALIS. June 7 and 8. Conducted by Dr. Thomas R. Boggs, Jr. of the Philadelphia Serum Exchange of the Children's Hospital of Philadelphia, under the auspices of the Graduate School of Medicine, University of Pennsylvania. Tuition — $50.00.

For information write to Irving J. Wolman, M.D., Children's Hospital of Philadelphia, 1740 Bainbridge Street, Philadelphia 46.

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## St. Anthony's Hospital, (Rockford) all day clinic

Speakers of national reputation have been invited to participate in an all day clinic to be held at St. Anthony Hospital, Rockford, on Wednesday, May 9. This will be of general interest to physicians in the Rockford area. For additional information, write to J. Howard Maloney, M. D., 802 Gas-Electric Building, Rockford, Illinois.

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## Lectures on medicine's growth

Northwestern University Medical School
Wednesdays 5:00-6:00, Thorne Hall

Archibald L. Hoyne, MD — AB — BS Professor of Pediatrics Chicago Medical School; Conquest of Contagious Diseases: April 18, 1956

Richard H. Young, Dean, BS — MD Professor of Medicine Northwestern Medical School; The Development of Medical Education in the United States: April 25, 1956.

Leslie B. Arey, ScD — PhD — LLD Robert Laughlin Rea, Professor of Anatomy Northwestern Medical School: Body Snatching, May 2, 1956.

Carlos I. Reed, PhD Professor of Physiology University of Illinois Medical School; Who First Isolated Insulin?: May 9, 1956.

E. M. K. Geiling, MD —PhD Professor of Pharmacology University of Chicago Medical School; John Jacob Abel: May 16, 1956.

Joseph A. Capps, MD — AM — ScD Clinical Professor Emeritus University of Chicago Medical School; Frank Billings: May 23, 1956.

Morris Fishbein, MD Professor of Medicine University of Illinois Rush Med. College Contributing Editor, Post Graduate Medicine; Birth and Growth of the American Medical Association: June 6, 1956.

## Open letter to the nation's doctors

Since its founding in 1949, the National Fund for Medical Education has concentrated almost wholly on obtaining corporation support for the nation's medical schools. Progress has been slow but steady. Each year has seen an increase over the previous one, both in the number and amounts of company contributions. In 1955 more than 1,500 business firms contributed nearly $1,700,000.

It is, of course, a long way from the $10 million additional annual income required by the schools. But it has shown us what is necessary to win corporation support: a painstaking — and persistent — campaign of education to show business leaders their stake in medical education.

The encouraging part of the picture is the readiness of business leaders to support medical education "once they know the facts." As Colby M. Chester, chairman of the Fund's Committee of American Industry, once said: "If we can get them to sit still long enough to listen, we can get their support."

Now I am not suggesting that physicians badger their patients for contributions to the Fund. But I am wondering if doctors cannot be a great ally of the Fund in bringing, in some way, the needs of the medical schools to the attention of the businessmen among their acquaintances. Certainly no one is better qualified to speak authoritatively than doctors. And no one could be more convincing.

Medical Education Week, it seems to me, provides an excellent occasion for beginning such an approach. It will be a period when the needs of the medical schools, as well as the achievements of medical science, will be discussed at meetings businessmen attend and in publications they read. Perhaps then, too, the approach can be followed up from time to time during the year.

Considering the role that the medical sciences have played in safeguarding the people's health, no one has to be timid or reluctant about broaching the subject of continued support for medical education. The testimony of the doctor, coming on the heels of appeals by industry leaders, can do much, in my opinion, to win the businessmen over. Once they are convinced, they are likely to become regular annual contributors to the Fund.

# AT THE EDITOR'S DESK



"There is a mistaken belief that memory declines as you grow older." This is discouraging news to those of us who have been using age as an excuse for not remembering the names of patients, places, and events. This New York release also says "Middle-aged people are more forgetful because they become less interested in learning new facts and they cling to familiar patterns of thinking and doing. It is not necessarily true that children are able to memorize more easily than adults; it depends upon the facts to be memorized."

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Among the new products introduced by large pharmaceutical houses is Hoffman-LaRoche's Azo Gantrisin,® an antibacterial-analgesic for urinary tract infections. It consists of Gantrisin plus phenylaxo-diamino-pyridine HCl for relief of local pain and discomfort.

Eli Lilly offers Tylandril® for the treatment of menopausal symptoms and osteoporosis. This product combines the advantages of estrogen-androgen therapy with the tranquilizing effects of reserpine. According to the release, the results are a greater feeling of well being; increased libido; and a lower incidence of breast turgidity, pelvic congestion, and nausea.

Lilly also markets Tes-Tape,® a small strip of bright yellow tape that enables a diabetic to make a colormetric determination of urine sugar in 60 seconds. Each dispenser holds enough tape for 100 tests. We understand the demand already exceeds the supply.

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Large doses of Levophed (nor-epinephrine), administered by continuous drip over a period of 11 days, brought about recovery in a patient with massive pulmonary embolism, according to an English physician. This report on one patient was used by Winthrop Laboratories as the basis for a news release on this production.

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The State Department of Public Health records no deaths among Illinois residents in 1954 from malaria, paratyphoid fever, Rocky Mountain spotted fever, tularemia, or smallpox. The last smallpox fatality was reported in 1938. Pneumonia and tuberculosis head the communicable diseases that cause death in this state.

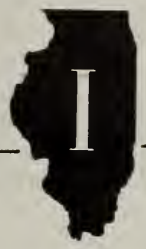
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The American Stair-Glide Corporation has introduced a portable home stairway elevator that can be installed in an hour without marking or scratching the floor or walls. The unit consists of a 12 inch aluminum track placed on the edges of the steps. The rider sits in a chair which contains the electrical and operating mechanism. The unit is plugged into any handy outlet and costs 10c a month to operate.

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From the Allergy Research Laboratory at Northwestern University Medical Center comes word that nearly 30 per cent of patients with symptoms of asthma or hay fever are sensitive to disintegrating bits of insect dust inhaled from air and soil. Hereafter, "sensitivity to dust" will be an inadequate diagnosis; it is necessary to know the offending agent in the dust. If insects are responsible, is it a disintegrated fly, moth, mite, bedbug, locust, bee, ant egg, or silk cocoon? As business and government get more complicated so does medicine!

# NEWS of the STATE



## COOK

**Loyal Davis Gives Hickey Lecture.**—On March 1, Dr. Loyal Davis, professor and chairman of surgery at Northwestern University Medical School, delivered the Hickey Memorial Lecture in Detroit on "Interrelationships Between Roentgenology, Radiology, Nuclear Physics and Neurological Surgery and their Joint Contributions to Medicine."

The lecture was in honor of Dr. Preston M. Hickey, prominent Michigan roentgenologist, who died in 1930. The lecture was presented under the auspices of the Wayne County Medical Society, Wayne University College of Medicine and the Detroit Roentgen Ray and Radium Society.

On the same day Dr. Davis addressed the students of the medical school. In this talk, he covered the twenty years of research at Northwestern University in which the physiological principles underlying the treatment of essential hypertension were studied.

**Michael Reese Honors Twenty-Five Physicians.**—At the annual staff meeting at Michael Reese Hospital, January 12, bronze plaques were presented to twenty-five Chicago physicians who have served the hospital for at least thirty years. Presentation of the plaques were made by President Grant J. Pick. The physicians honored were: Drs. Leon Bloch, Ralph B. Bettman, William A. Brams, Joseph K. Calvin, Joseph S. Eisenstaedt, Jesse R. Gerstley, Irvin S. Koll, Eugene P. Lieberthal, Samuel J. Pearlman, Morris L. Parker, Ralph A. Reis, Harry C. Rolnick, Philip Rosenblum, Samuel Salinger, David L. Schram, William A. Smiley, Alfred A. Strauss, Sidney Strauss, Irving F. Stein, Ervin P. Zeisler, William H. Rubovits and Robert A. Arens.

Posthumous awards were made to Drs. Isaac Abt, Julius Hess and Jacob Meyer.

**A Talk on "Our Daily Blood" Honors Dr. Hektoen.**—Dr. John K. Gibson, II, research associate in medicine, Harvard University Medical School, Boston, delivered the third Dr. Ludvig Hektoen Memorial Lecture, February 23, on "Our Daily Blood."

The lecture was sponsored by the Hektoen Institute for Medical Research of the Cook County Hospital.

**Physician Named Woman-of-Distinction.**—Dr. Beatrice E. Tucker was one of three women to receive Woman-of Distinction awards by the Women's Advertising Club of Chicago. She, with the other two award winners, were presented to a capacity audience in the Eighth Street Theatre, February 6. Dr. Tucker, who is certified by the American Board of Obstetrics and Gynecology, has been medical director of the Chicago's Maternity Center since 1932 when she succeeded Dr. Joseph B. DeLee, founder of the center. In addition to holding membership in her county, state, American Medical Association and other local and national organizations, Dr. Tucker is senior attending obstetrician and gynecologist at Wesley Memorial Hospital; associate attending obstetrician at Chicago Lying-In Hospital, and assistant professor of obstetrics and gynecology at Northwestern University Medical School.

**Tuberculosis Institute Observes Fiftieth Anniversary.**—More than 750 professional and non-medical persons interested in tuberculosis control attended the annual spring conference of the Tuberculosis Institute of Chicago and Cook County, March 14-16, at the Hotel Sherman. This session marked the fiftieth anniversary of the founding of the institute. "A look at the fifty years behind and the fifty years which lie ahead" opened the meeting, when speakers were Drs. Morris Fishbein, former editor of the Journal of the American Medical Association; Walter C. Bornemeier, Institute board member, and James E. Perkins, managing director of the National Tuberculosis Association.

Philip M. Hauser, Ph.D., director, Chicago Community Inventory, University of Chicago; Dr. Her-

man N. Bundesen, president, Chicago Board of Health, and Jane M. Hoey, director of social research, National Tuberculosis Association, discussed Chicago's changing nature, Chicago's people and their diseases, and methods of TB treatment supplementing medicine.

"The Moving Target," a discussion of case-finding emphasizing the tuberculin test, the mass survey, general hospitals and clinics, and the private physician was a feature. Speakers included Drs. Floyd M. Feldmann, medical director of the National Tuberculosis Association; M. R. Lichtenstein, medical director, Municipal Tuberculosis Sanitarium, Chicago; David B. Radner, medical director of Winfield Hospital, Winfield, Ill; Herbert Ratner, director of public health, Village of Oak Park, and Eugene T. McEnery, Institute board member. Another session concentrated on rehabilitation, "Now is Tomorrow," with topics encompassing laws, social service, welfare and future goals. Speakers were Charles O'Brien, chairman of the Statewide Committee to Amend the Workmen's Compensation Act; Miss Metta Bean, Wisconsin Anti-Tuberculosis Association; Mrs. Ruth Schley Goldman, of the Chicago Department of Welfare, and A. Ryrie Koch, rehabilitation, National Tuberculosis Association.

The Chicago Tuberculosis Society and the Institute held a joint meeting during the conference. Dr. Edna M. Jones, Maybury Sanatorium, Northville, Mich., spoke on the tuberculin test; Dr. William M. Tuttle, professor of surgery, Wayne University College of Medicine, Detroit, gave a review of pulmonary surgery, and Dr. Michael Furculow, medical director, University of Kansas Medical Center, Kansas City, Kan., discussed fungus disease. Other features, dealing with professional techniques used by health educators, nurses, rehabilitation workers and community organizers, were in the nature of seminars. "Patient-Family—Community Education" was the theme of one program.

**Derrick Vail Tours Army Hospitals in European Command.**—Dr. Derrick Vail, professor and chairman of ophthalmology at Northwestern University Medical School, began a thirty day tour of the U. S. Army hospitals in the European Command, February 6. Dr. Vail, who was serving as a consultant in ophthalmology at the special request of the surgeon general of the U. S. Army, toured sixteen army hospitals in Berlin, Heidelberg, Munich, Frankfort, Paris and other European cities. He gave a series of lectures to medical officers in the hospitals and participated in informal discussions, conferences, ward rounds and examination of patients. He was guest lecturer at the annual medical-surgical conference of all medical officers in the European Command held in Frankfort, Germany, February 17-18.

**Ludvig Hektoen Memorial Lecture.**—Sidney Weinhouse, senior member and head of the x department of metabolic chemistry, the Lankenau Hospital Research Institute and the Institute for Cancer Research, Philadelphia, gave the thirty-first Ludvig Hektoen Memorial Lecture of the Institute of Medicine of Chicago, March 5. This was a joint meeting with the Chicago Diabetes Association. Dr. Weinhouse's subject was "Studies of Fat Metabolism in Experimental Diabetes".

**The D. J. Davis Memorial Lecture.**—On May 9, Carlos I. Reed, Ph.D., professor of physiology at the University of Illinois College of Medicine, will give the annual D. J. Davis Memorial Lecture on Medical History. The lecture, which will be titled "John Morgan, Father of the First American Medical School", will be given in room 221 of the Medical-Dental-Pharmacy Building at the University of Illinois College of Medicine.

**Personal.**—Dr. Eugene Derlacki will discuss "Clinical Evaluation of Food Sensitization in Perennial Nasal Allergy" at the annual session of the American Medical Association in Chicago in June. —Dr. Earl E. Barth, professor of radiology at Northwestern University Medical School, has been elected to the Board of Chancellors of the American College of Radiology.

## DEKALB

**New Officers.**—Dr. Grant Suttie, DeKalb, was named vice-president and president-elect of the DeKalb County Medical Society, at its meeting in February and, Dr. Otto Keller, DeKalb, was installed as president. Other officers are: Drs. Carl E. Clark, Sycamore, secretary-treasurer; J. C. Ellis, DeKalb, delegate; H. J. Trapp, Sycamore, E. B. Glenn, DeKalb and E. J. Fenwick, Sycamore, censors. Members of the Grievance Committee are: Drs. J. W. Ovitz, Sr., Sycamore; E. W. Telford, DeKalb; P. W. Carney, DeKalb; H. J. Trapp, Sycamore; J. W. Ovitz, Jr, Sycamore, and R. S. Keller, Sandwich.

**Physician's Son Wins Science Award.**—John B. Clark, son of Dr. and Mrs. Carl E. Clark, Sycamore, has won the $2,000 second place Westinghouse science scholarship, newspapers reported March 6, 1956.

John is planning to take a pre-medical course at the University of Illinois after he is graduated from high school in June. He hopes to become a pathologist or biochemist.

The prize winner is the son of the Councilor of the First District of the Illinois State Medical Society, Dr. Clark, who is also secretary of the DeKalb County Medical Society.

John, who is 18 years old, shared in the $11,000 awarded by the Westinghouse Educational Foundation, financed by the Westinghouse Electric Corporation, for scholarships in its fifteenth annual science talent search.

## DUPAGE

**Woman's Club and Physicians Cooperate in Emergency Service.**—The Wheaton Junior Woman's Club members recently stamped water meter

bills with the phone numbers of physicians available for emergency service as a part of the local publicity for the Wheaton Emergency Physicians' Service which was established December 17, 1954. The Daily Journal, February 2, carried an excellent story on the cooperative effort of the members of the Woman's Club together with a description of the service. It said in part: "A team of doctors is on duty each week end from 6 p.m., Saturday, until 7 a.m., Monday, and on all holidays throughout the year. Doctors' office hours are staggered so that each hour of each day through the week a physician is always available for emergency service.

It is suggested that if you do not at present have a family physician, now is the time to select one. Introduce yourself and family. Don't wait for a tragic emergency before you select your family doctor."

## HENDERSON

**Town Honors Two Professional Men.**—Biggsville held a dinner, February 9, in honor of two of its oldest business and professional men, Dr. Milton Babcock and Mr. Clyde Dixon, the village blacksmith. Dr. Babcock was presented with the insignia emblematic of the membership in the Fifty Year Club of the Illinois State Medical Society. The presentation was made by Dr. Charles P. Blair, Monmouth, Councilor for the Fourth Councilor District of the Illinois State Medical Society. Mr. Dixon is starting his sixtieth year in the general blacksmithing business. With Dr. Babcock, the other two physicians in the county, Drs. Harold Bock, Stronghurst, and Elmer Swann, Oquawka, were present at the dinner.

## MADISON

**Society News.**—"A Present Knowledge of Viral Diseases" was the subject of Dr. John P. Wyatt, St. Louis, before the Madison County Medical Society at the St. John's Methodist Church, Edwardsville, February 2. Dr. Wyatt is professor of pathology and associate director of the department of pathology at St. Louis University School of Medicine.

**New Members.**—At its January meeting, the Madison County Medical Society accepted Drs. John P. Darling and Melvin J. Freedman into membership.

## PEORIA

**Society News.**—Dr. Nicholas Nyaradi, chairman of the department of economics of Bradley University, addressed the Peoria Medical Society, February 21, at the Hotel Pere Marquette. This was the annual joint meeting with the Woman's Auxiliary to the society.

## ST. CLAIR

**New Officers.**—At the recent annual meeting of the St. Clair County Medical Society, Dr. H. L. Lange was named president-elect. Dr. H. H. Hurd was inducted as president. Other officers are: Drs. V. P. Siegel, vice-president; Lloyd J. Hill, secretary; William E. Knaus, treasurer; S. W. Mauch, editor, and M. Eisele and J. J. McCullough, associate editors.

**Society News.**—At the March 1 meeting of the St. Clair County Medical Society at the Trailway Restaurant, Dr. William Masters, associate professor of obstetrics and gynecology at the Washington University School of Medicine, St. Louis, spoke on "The Use of Hormones."

## SANGAMON

**Dynamics of Modern Rehabilitation.**—"The Rehabilitation Team and the Family Physician" was the subject of Drs. H. Worley Kendall and Joseph Schaeffer before the regular meeting of the Sangamon County Medical Society at the Elks Club, Springfield, March 1.

Perhaps this program can best be described by quoting Dr. Emmet F. Pearson from his President's Page in the Bulletin of the Sangamon County Medical Society. He said: "We shall have the extraordinary opportunity of seeing some of the dynamics of modern rehabilitation enacted for us by Dr. H. Worley Kendall, director of the Peoria Institute for Physical Medicine and Rehabilitation, his associate, Dr. Joseph Schaeffer, and a team of twelve assistants. They will arrive in three station wagons with a galaxy of equipment and gadgets.

Doctor Kendall is a real pioneer in the modern art and science of rehabilitation and was professor of physical medicine and rehabilitation at the University of Illinois before he assumed his present position in Peoria. The Peoria institute has rapidly gained statewide and worldwide acclaim. We are fortunate to have an institute of such outstanding nature in central Illinois.

Rehabilitation looks at the "whole" individual. The objective is to restore a disabled person to his maximum physical, emotional, social and economic capacity. This is usually a big order and requires a group of experts in many fields all working as a team toward the same goal. It has been said that rehabilitation has three major phases: restoration, conservation, and cultivation. From the rehabilitation point of view the abilities are developed and the disabilities played down.

In concluding his comment on the meeting, Dr. Pearson said "the family physician's office is the place where most disabled people are known and the doctor is the most anxious member of the community team to accomplish rehabilitation in his patients."

**Society News.**—Dr. Richmond W. Smith, Jr., physician in charge of the division of endocrinology at the Henry Ford Hospital, Detroit, addressed the Vermilion County Medical Society at the Hotel Wolford, Danville, March 6, on "Clinical Variants in Adrenal Corticol Hyperfunction."

**Physicians Meet With Lawyers.**—"Medical and

Legal Aspects of Vehicle Injuries" was discussed at a joint meeting of the Vermilion County Medical Society and Bar Association, February 7. Dr. Frank P. Cleveland was the speaker. Among other positions, Dr. Cleveland is assistant professor of industrial health and pathology at the University of Cincinnati College of Medicine, lecturer in legal medicine at Salmon P. Chase College of Law and pathologist to the coroner and assistant coroner of Hamilton County.

## WARREN

**Rotary Club Hears Talk on Intoximeter.**—Dr. Franz Lengh, pathologist on the staffs of Galesburg Cottage and St. Mary's hospitals, addressed the Monmouth Rotary Club, February 6, on the use of the intoximeter in detecting the alcoholic content of the blood. He also discussed the breath tests through the use of balloons which are being used extensively by the legal authorities in Warren and Knox counties, two of the first counties in Illinois to adopt the procedure. Dr. Lengh's talk included interesting statistics on the high percentage of highway accidents in which the use of alcohol was a prime factor.

## GENERAL

**Chicago Welfare Commissioner Honored.**—Alvin E. Rose, commissioner of welfare of the city of Chicago, was named the outstanding Chicago public servant for 1955 by the Chicago Junior Chamber of Commerce, the Chicago Tribune reported March 5, 1956. The group, which is better known as the Chicago Junior Association of Commerce, reported that Mr. Rose was chosen for his leadership in developing the first large scale public welfare program to emphasize rehabilitation of the individual. Mr. Rose, who has been welfare commissioner since 1946, was honored at a dinner, March 23, sponsored by the good government award committee of the association, the Tribune announced.

**Postgraduate Conferences.**—The Postgraduate Education Committee of the Ilinois State Medical Society has arranged, in cooperation with the designated groups, the following postgraduate conferences:

With the Effingham County Medical Society as host, the conference in Effingham, March 7, was presented by members of the staff of Henrotin Hospital. Speakers were Drs. James H. Cross, Postoperative Nutrition; John R. Wolff, Use of Pitocin in Labor; Caesar Portes, Office Proctology; James D. Majarakis, Current Progress in the Treatment of Advanced Carcinoma, and Louis C. Johnston, High Blood Pressure. Dr. F. Lee Stone, President-Elect of the Illinois State Medical Society, gave the dinner address on "Professional Liability."

With the DuPage County Medical Society as host, the conference in Elmhurst, March 21, was presented by members of the staff of Chicago Wesley Memorial Hospital. "Management of Suspicious Chest Lesions and Indications for Exploratory Surgery" was the subject of one panel discussion by Drs. Theodore R. Hudson, moderator, Abram H. Cannon and James B. Hurd. "Low Back Pain" was the theme of the second panel presentation by Drs. William J. Schnute, as moderator, and H. R. Oberhill and B. M. Peckham. Dr. Theodore R. Van Dellen, as dinner speaker, discussed "Newspaper Medicine."

With the Morgan and Sangamon County Medical Societies acting as hosts, the conference in Jacksonville, March 22, was presented by members of the faculty of Stritch School of Medicine of Loyola University. Physicians covering the subject of "Common Blood Disorders" in one panel discussion were George O'Brien, moderator, Peter J. Talso, Raymond J. Dern, and John J. O'Brien. A second panel discussion was devoted to "Surgical Lesions of the Colon." Dr. Harry A. Oberhelman acted as moderator; other participants were Drs. John B. Condon, Anthony C. Guzauskas, and James A. Rooney. Dr. Oberhelman also addressed the afternoon session on "Surgical Lesions of the Breast." Mr. Oliver Field, Director of the Bureau of Investigation, American Medical Association, gave the dinner address on "Quackeries in Medicine." When the ILLINOIS MEDICAL JOURNAL went to press, completed programs were not available for the following conferences: April 5, Belleville, members of the staff of St. Luke's Hospital; April 12, Monmouth, members of the staffs of Northwestern University Medical School and the University of Illinois College of Medicine; April 19, Decatur, members of the staff of Passavant Memorial Hospital, and April 26, Mattoon, members of the staff of the Cook County Graduate School of Medicine.

**"Your Doctor Speaks" on FM Station WFJL.**—The following physicians have recently appeared in transcribed broadcasts of FM. Station WFJL, Thursday evenings at 7:45 p.m. The series, entitled "Your Doctor Speaks," is presented by the **Educational Committee** of the **Illinois State Medical Society:**

**Louis C. Johnston, Jr.**, clinical assistant in medicine, University of Illinois College of Medicine, March 1, on High Blood Pressure.

**William B. Fischer**, clinical assistant in orthopedics, Northwestern University Medical School, March 8, on The Bone and Joint Problem.

**Charles V. Heck**, clinical assistant professor of orthopedic surgery, University of Illinois College of Medicine, March 15, on The Painful Shoulder and Elbow.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**John O. Firth**, a member of the staff of Monmouth Hospital, Washington Women's Club, April 3, on Preventive Medicine.

**Joseph A. Bertucci,** clinical instructor in pediatrics, Stritch School of Medicine of Loyola University, St. Monica's Guild of St. Christopher's Church, April 5, on Feeding Problems in Children.

**Joseph T. O'Neill,** Ottawa, Chairman of the Council of the Illinois State Medical Society, Washington School Parent-Teacher Association, April 18, on Emotional Balance Helps the School Child.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Ralph Kinsella, Jr.,** associate professor of internal medicine, St. Louis University School of Medicine, Montgomery and Macoupin County Medical Societies, Litchfield, February 29, on Fetal Endocrinology: A New Field for Clinical Investigation.

**Frederick L. Phillips,** attending pediatrician at St. Luke's Hospital, La Salle County Medical Society, LaSalle, March 8, on Common Emergencies in Infancy.

**John M. McCuskey,** member of the active staff of the Methodist Hospital, Peoria, Henry County Medical Society, Kewanee, March 14, on Use and Misuse of Steroids.

**John R. Wolff,** assistant professor of obstetrics and gynecology, University of Illinois College of Medicine, Knox County Medical Society, Galesburg, March 15, on Office Gynecology.

**Winston H. Tucker,** Public Health Director of Evanston, Kankakee County Medical Society, Kankakee, March 20, on Recent Advances in the Field of Poliomyelitis.

**Irving E. Steck,** clinical assistant professor of medicine, University of Illinois College of Medicine, Whiteside-Lee County Medical Societies, Rock Falls, April 19, on Diagnosis and Treatment of Rheumatoid Diseases.

**E. Clinton Texter,** associate in medicine, Northwestern University Medical School, Stock Yards Branch of the Chicago Medical Society, Evangelical Hospital, April 20, on Newest Drugs for the Treatment and Management of Peptic Ulcer.

**John R. Wolff,** chairman of the department of obstetrics and gynecology, Henrotin Hospital, DeKalb County Medical Society, Sycamore, April 24, on Common Perplexities Seen in Office Practice.

## DEATHS

**Thomas D. Allen*,** Chicago, who graduated at Rush Medical College in 1915, died February 14, aged 67. He was clinical associate professor of ophthalmology at the University of Illinois College of Medicine, a member of the staff of the Presbyterian Hospital, and secretary-treasurer of the Pan-American Association of Ophthalmology.

**Hugh Quitman Allison,** Grayville, who graduated at Barnes Medical College, St. Louis, in 1909, died December 26, aged 72. He served on the courtesy staff of the Wabash General Hospital in Mount Carmel.

**Leslie E. Bovik*,** Lake Forest, who graduated at Chicago College of Medicine and Surgery in 1915, died March 5, aged 64. He was a member of the staffs of Lake Forest Hospital, and also St. Therese and Victory Memorial Hospitals in Waukegan.

**Mitchell S. Corbett*,** Oak Park, who graduated at Jenner Medical College in 1911, died February 29, aged 72. He was the founder and head of the Corbett Clinic and had been staff physician of the Chicago Stadium and the Illinois Athletic Commission since 1930.

**Charles Edward Donahoo,** East Moline, who graduated at Keokuk Medical College, College of Physicians and Surgeons, in 1903, died December 1, aged 75, of coronary thrombosis.

**Ralph W. Erikson*,** Chicago, who graduated at Rush Medical College in 1925, died February 13, aged 56. He was a member of the staff of the Swedish Covenant Hospital.

**David Fitzgerald*,** Northfield, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died February 29, agted 75. He had practiced medicine in Chicago since 1906.

**Morris H. Gindich*,** Lake Villa, who graduated at the Chicago Medical School in 1923, died February 27, aged 62, while vacationing in Miami Beach, Florida. He was a member of the staffs of Columbus and St. Theresa Hospitals in Waukegan.

**John Joseph Hanlon,** Chicago, who graduated at Loyola University School of Medicine in 1928, died December 21, aged 52, of coronary occlusion.

**Lee Collins Harlan*,** Madison, who graduated at Barnes Medical College, St. Louis, in 1907, died December 4, aged 70, of cerebral hemorrhage and hypertension. He was a member of the staff of St. Elizabeth's Hospital in Granite City.

**Albert P. Hedges*,** retired, Evanston, who graduated at Chicago Homeopathic Medical College in 1890, died February 14, in the Presbyterian Home, Evanston, aged 92. He had practiced medicine in Chicago for 58 years and was formerly a staff member of the Illinois Masonic, Lake View and Ravenswood hospitals.

**Clarence W. Hennan*,** Chicago, who graduated at the Chicago College of Medicine and Surgery in 1917, died February 28, aged 61. He was a past president of the Jackson Park Hospital staff, and of the Chicago Society of Industrial Medicine and Surgery.

**Disraeli W. Kobak*,** Chicago, who graduated at the University of Illinois College of Medicine in 1913, died February 17, aged 69. He was head of the physical therapy division of the Cook County Hospital and the Oak Forest Infirmary, and editor emeritus of the Archives of Physical Therapy.

**Ernest A. Lowinger,** Chicago, who graduated at Illinois Medical College in 1909, died March 4, in Miami Beach, aged 70. He was chief of the bureau of vital statistics in the city health department from 1933 to 1947.

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*Members of the Illinois State Medical Society.

**David C. Ryan***, Peoria, who graduated at St. Louis University School of Medicine in 1939, died February 3, aged 45.

**William E. Schowengerdt***, Champaign, who graduated at Missouri Medical College in 1897, died March 2, aged 83. He had served as public health officer in Champaign-Urbana for 30 years; member of the Champaign School Board for 34 years; in 1950 was named outstanding general practitioner by the Champaign County Medical Society; and in 1955 received the Champaign Exchange Club's "Golden Deeds" award for his outstanding services to the community.

**Leslie B. Sims***, Farmington, who graduated at Northwestern University Medical School in 1907, died February 3, aged 76.

## CORRECTION

The death of Jack L. Greider, Decatur, member of the Macon County Medical Society, was erroneously reported in THE ILLINOIS MEDICAL JOURNAL, February 1956. Dr. Greider, who is alive and well, is living in Decatur. It was Frank Croft Greider*, Decatur, a graduate of St. Louis University School of Medicine in 1933, who died in Los Angeles, December 19, aged 60, when struck by an automobile.

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*Indicates member of the Illinois State Medical Society.

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## Area consultant committees to assist Army

Six committees on civilian consultants to the Army Surgeons in the zone of the interior have been formed by The Surgeon General, in cooperation with the Society of Medical Consultants to the Armed Forces.

The committees, which have a membership of at least three outstanding physicians in the area, represent the fields of medicine, surgery, and neuropsychiatry. They will be called upon to assist the Army Surgeon in the professional appraisal, procurement, and appointment of professional consultants to local medical installations; in the supervision of civilian medical consultants in Class I Army medical installations; and in other matters pertaining to the maintenance of the highest standards of professional performance within the command.

Committee chairmen of each of the Army areas are:

First Army — Bruce Webster, MD, New York City.

Second Army — I. S. Ravdin, MD, Philadelphia

Third Army — Joseph S. Skobba, MD, Atlanta

Fourth Army — Perry C. Talkington, MD, Dallas

Fifth Army — James B. Mason, MD, Chicago

Sixth Army — Manfred U. Prescott, MD, San Francisco, California.

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## Cancer and diverticulitis

There are certain clinical signs that will help to differentiate cancer and diverticulitis. Daily rectal bleeding, in which the blood is mixed with feces or mucus is much more typical of cancer. Patients whose symptoms do not subside rapidly on medical therapy also must be considered suspects. In a few instances, it has been possible to obtain positive cytological smears on rectal washings. They are much more likely to be satisfactory if the patient has had colostomy performed previously. Also, if the patient does not improve after colostomy and rapid resolution of the pelvic mass does not occur, the chances are that the lesion is cancer. *Claude E. Welch, M.D. The Problem of Diverticulitis. California Med. Dec.* 1955.



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*Pediatric Bibliography*


1. Wikler: The Use of Chlorpromazine as an Anti-emetic in Children, Arch. Pediat. *72*:197 (June) 1955.
2. Daeschner et al.: Chlorpromazine in the Control of Vomiting in Children, Am. J. Dis. Child. *89*:525 (May) 1955.
3. Steigman and Vallbona: Chlorpromazine, A Useful Antiemetic in Pediatric Practice, J. Pediat. *46*:296 (March) 1955.
4. Steigman and Vallbona: Experience with Chlorpromazine in Pediatrics, Internat. Rec. Med. & Gen. Pract. Clinics *168*:351 (May) 1955.
5. Moyer et al.: Clinical Studies of an Anti-emetic Agent, Chlorpromazine, Am. J. M. Sc. *228*:174 (Aug.) 1954.


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# BOOK REVIEWS

A TEXTBOOK OF CLINICAL PATHOLOGY, 5th EDITION Editor: Miller, S. E., Medical Director, United States Public Health Service Chief, Division of Special Health Services. Publisher: The Williams & Wilkins Company, Baltimore. 1208 Pages Price: $11.00 1955

This 5th edition of this standard textbook has been considerably revised. New chapters on medical bacteriology, mycology, parasitology, seminal fluid and feces have been added. Other chapters have been redesigned and rewritten, including those on renal function tests, sputum, hematology, liver function tests, vitamins, hormone assay and serology of syphilis.

This creates a larger text, by 150 pages, but also a more comprehensive one. Although written by various authors, the chapters fit together harmoniously and the book performs well the task for which it is intended; that is to give the medical student, interne, resident, and teacher of medicine a source of information on how to use the laboratory adequately.

J. C. S.

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ESSENTIALS OF ORTHOPAEDICS. By Philip Wiles, M.S., F.R.C.S., F.A.C.S., Senior Orthopaedic Surgeon, Middlesex Hospital, London and King Edward Memorial Hospital, Ealing; Lecturer in Orthopaedic Surgery, University of London; President Elect, British Orthopaedic 1955. London: J. & A. Churchill Ltd. Price $10.00

This work, the second edition, covers many revisions, and several sections have been rewritten in comparison with the first edition.

In his preface the author states, "I have tried to confine myself to the elements of the subject, both physiological and pathological, and their application to diagnosis and treatment.

Every page has been corrected or revised and there is not a chapter without major alterations to several sections. Many of the old illustrations have been replaced by better examples, a few have been omitted, and about thirty new figures have been added."

The various subjects are presented sufficiently and all details are clearly expressed.

This new volume covers especially well congenital dislocation of the hip, sciatica, ischaemic contractures, bone tumors, and the etiology of postural defects. The effect and cure of deformities of the feet that are due to the high heel is dealt with in few words but scientifically and succinctly. There are many other particular items that might be commended.

Essentials of orthopedics is the title, and the contents do not belie the title, the essentials are all included and discussed. The author's extensive experience and his editorial ability to examine the literature and glean from it the ideas that add factual data and the knowledge of others in the field of Orthopedics, these qualifications of the author have enabled him to present a book quite outstanding and well worth being studied by any one interested in orthopedics. (and what physician isn't?)

C. P. B.

(*Continued on page* 50)


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## BOOK REVIEWS (Continued)

TEXTBOOK OF ENDOCRINOLOGY. Edited by Robert E. Williams, M.D., Executive Officer and Professor of Medicine, University of Washington Medical School, Seattle. Contributors: William H. Daughaday; Peter H. Forsham; Henry B. Friedgood; John Eager Howard; Edward C. Reifenstein, Jr.; William W. Scott; George Van S. Smith; George W. Thorn; Lawson Wilkins; Robert H. Williams. Second edition. Pages 776 with 175 figures. W. B. Saunders Company, Philadelphia — London, August 31, 1955. Price $13.00.

This book is divided into 13 chapters as follows: Chapter 1. General Principles of the Physiology of the Endocrines, by Robert H. Williams (10 pages); Chapter 2. The Pituitary, by Robert H. Williams (88 pages); Chapter 3. The Thyroid, by Robert H. Williams (122 pages); Chapter 4. The Adrenals, by Peter H. Forsham and George W. Thorn (95 pages); Chapter 5. The Testes, by John Eager Howard and William Wallace Scott (34 pages); Chapter 6. The Ovaries, by George V. Smith (53 pages); Chapter 7. The Pancreas, by Peter H. Forsham and George W. Thorn (80 pages); Chapter 8. Diseases of the Parathyroid Glands, by Edward C. Reifenstein, Jr. (99 pages); Chapter 9. The Influence of the Endocrine Glands upon Growth and Development, by Lawson Wilkins (27 pages); Chapter 10. Neuroendocrinology, by Harry B. Friedgood (36 pages); Chapter 11. Obesity, by William H. Daughaday (22 pages); Chapter 12. Laboratory Diagnostic and Assay Procedures, by Robert H. Williams and Others (66 pages); and Chapter 13. Diagnosis and Treatment of Endocrinopathies; Hormone Preparations, by Robert H. Williams (11 pages).

The contributors are authorities in their fields and have produced a work that would be a valuable addition to any physician's library and of especial value to endocrinologists.

The chapter dealing with the adrenals is outstanding. Only a few years ago we were uncertain as to the nature of the adrenal cortex hormones, if any. Now we possess methods of determining with a fair degree of accuracy the nature and amount of these hormones. The

(*Continued on page* 58)


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methods for making these tests are described in detail in this chapter and in Chapter 12 dealing with laboratory procedures. The authors seem to prefer the presacral route for extraperitoneal pneumography to perirenal insufflation. They say the presacral method is not associated with the danger of oxygen emboli which has led some to abondon perirenal insufflation.

However, those who have had considerable experience with the perirenal method claim that the deaths reported in connection with it have not been due to air embolism but to the vasovagal reflex. This, they claim, can be abolished by the prior injection of a local anesthetic so that the method, in their opinion, is practically free from danger. They also claim that it gives a better idea as to the size and location of the adrenal tumor or hyperplasia. (Z. Z. Godlowski, M.D., Ph.D., M.R.C.P. Ed: The Value of the Perirenal Insufflation of Air as a Diagnostic Method of Estimating Gross Anatomical Enlargement of the Suprarenals and Kidneys. Journal of the Faculty of Radiologists Vol. V. No. 2, Pp. 148-155, October 1953).

The conservative discussion of thyroid cancer is refreshing. The author quotes Crile as estimating that it would be "necessary to remove 6,675 solitary and apparently benign adenomas of the thyroid in order to prevent one patient's dying of cancer of the thyroid."

The chapter on the pancreas is interesting and helpful. Undoubtedly readers will regret that the authors did not continue their interesting discussion to include something about the "brittle" diabetic.

The short chapter on obesity is no indication of its importance but rather of our lack of knowledge of its ultimate etiology and pathogenesis.

The chapter on the pituitary might well have included some discussion of procedures for preventing gigantism.

The book is a valuable reference work.

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Temper your enjoyment with prudence lest there be written on your heart that fearful word, satiety. — Quarles


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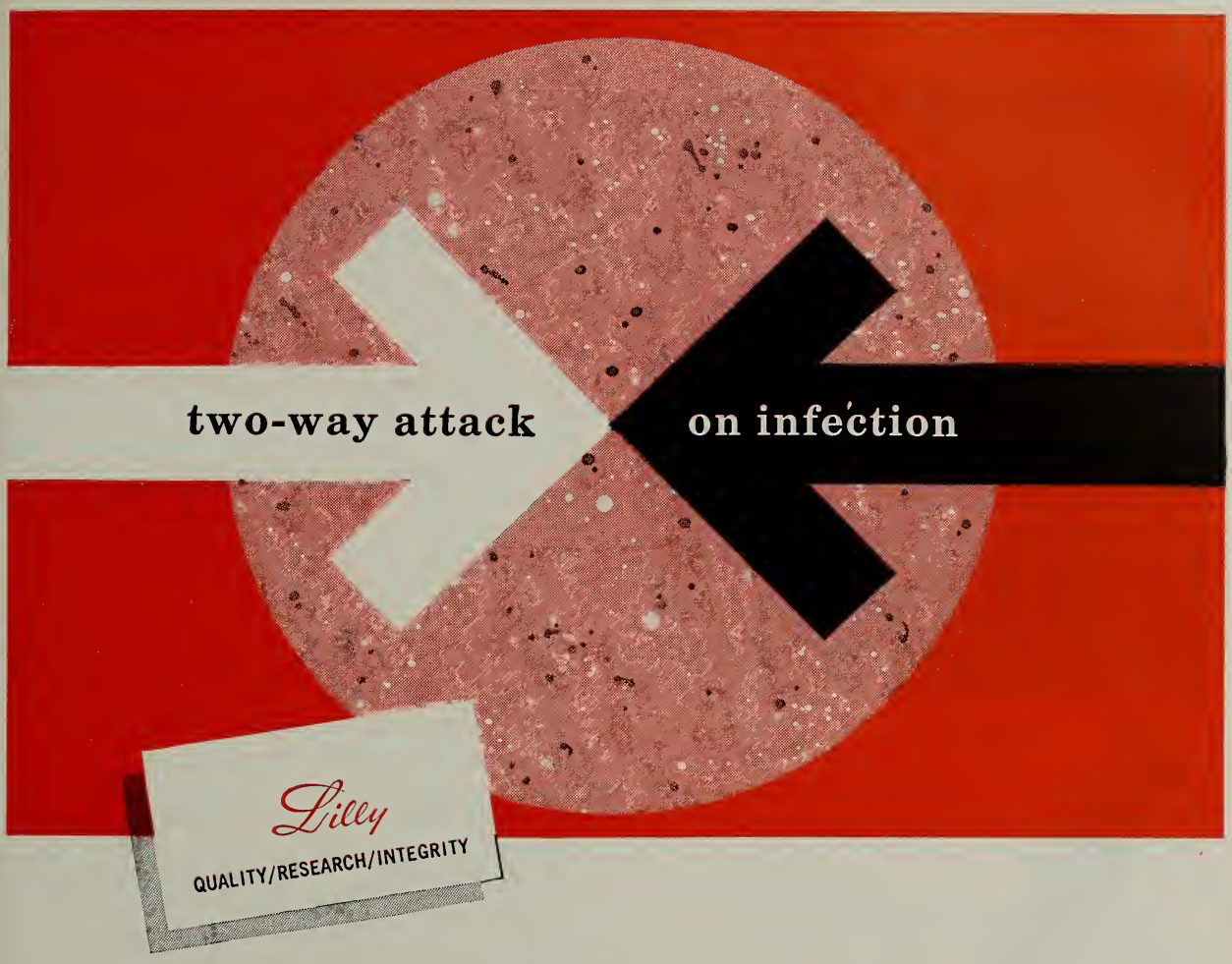
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*References:* 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. *68*:559 (Aug.) 1954. 2. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955. 3. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955.

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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

A Course in Practical Therapeutics. By Martin Emil Rehfuss, M.D., F.A.C.P., LL. D. (Hon.), Professor of Clinical Medicine, Emeritus, and Director of the Division of Therapeutics in the Department of Medicine, The Jefferson Medical College, Philadelphia; Attending Physician, The Jefferson Medical College Hospital, Philadelphia, and Alison Howe Price, A.B., M.D., Associate Professor of Medicine, The Jefferson Medical College, Philadelphia; Asst. Physician to The Jefferson Medical College Hospital, Philadelphia; Chief Clinical Assistant Diabetic Clinic, Curtis Clinic, Philadelphia. Third Edition. The Williams & Wilkins Company, Baltimore, 1956. $15.00.

Clinical Electrocardiography. Part 1. The Arrhythmias. With an Atlas of Electrocardiograms. By Louis N. Katz, A. B., M. A., M.D., F. A. C. P. Director, Cardiovascular Department, Michael Reese Hospital, Chicago, Illinois; Professorial Lecturer in Physiology, University of Chicago, Chicago, Illinois, and Alfred Pick, M.D., Physician-in-Charge of Heart Station and Research Associate, Cardiovascular Department, Michael Reese Hospital, Chicago, Illinois. Illustrated with 415 engravings. Lea & Febiger, Philadelphia, 1956. $17.50.

Diseases of the Chest. By H. Corwin Hinshaw, M.D., Ph.D., Clinical Professor of Medicine, Stanford University School of Medicine and L. Henry Garland, M.B., B. Ch., Clinical Professor of Radiology, Stanford University School of Medicine. 727 pages. 634 illustrations on 277 figures. W. G. Saunders Company, Philadelphia and London. $15.00.

Current Therapy 1956. Latest Approved Methods of Treatment for the Practicing Physician. Editor: Howard F. Conn, M.D. Consulting Editors: George E. Burch; M. Edward Davis; Vincent J. Derbes; Garfield G. Duncan; Hugh J. Jewett; Perrin H. Long; H. Houston Merritt; Paul A. O'Leary; Walter L. Palmer; Hobart A. Reimann; Cyrus C. Sturgis; Robert H. Williams. 632 pages. W. B. Saunders Company, Philadelphia and London. $11.00.

Diagnosis and Treatment of Vascular Disorders (Angiology) Edited by Saul S. Samuels, A. M., M.D., F. A. C. A., F. A. C. C., The Williams and Wilkins Company, Baltimore, 1956. $16.00.

Christopher's Textbook of Surgery. Editor: Loyal Davis, M.D., Chairman of the Department of Surgery, Northwestern University Medical School. Sixth Edition. 1484 pages. 1359 illustrations on 716 figures. W. B. Saunders Company, Philadelphia and London, $15.50.

## A differential diagnosis

The possibility of erroneously diagnosing rheumatic heart disease in cases of uncomplicated hyperthyroidism seldom offers real difficulty. Patients with mitral stenosis and hyperthyroidism generally have signs of the former, with a pronounced presystolic rumbling murmur — a murmur which, because of cardiac overactivity — is exaggerated during the period of thyroid intoxication. The examiner should not be too easily misled by less definite suggestions such as a systolic shock or any ill-defined thrill palpated at the cardiac apex. The peripheral arterial phenomena, which are common in aortic incompetence and which occur in the majority of instances of hyperthyroidism (increased pulse pressure, Corrigan pulse, throbbing arteries, and pistol shot sounds over femoral artery), should serve merely to stimulate the examiner to consider the diagnosis of hyperthyroidism. This is especially true if tachycardia is present and the diastolic murmur of aortic incompetence is absent. *F. Janney Smith, M.D. The Clinical Features of Hyperthyroidism. Heart Bull. Nov.-Dec. 1955.*


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## The source of gas

The once prominent role of putrefaction as the source of gas has long since been reassigned to what is loosely called air swallowing. It is now known, as the result of many analyses of intestinal gases, fluoroscopic and radiologic observations, and animal and human experimentation, that 70 per cent of the gas found in the gastrointestinal tract — even in cases of intestinal obstruction — results from the ingestion of air. Moreover, it has been shown that even the muscular act of swallowing is not necessary for the transport of air from mouth to stomach. Indeed, it appears that another mechanism of air ingestion, involving unconscious relaxation of the superior esophageal sphincter and the creation of negative pressure in the esophagus as the result of inspiration against a closed glottis, is capable of drawing 1,000 to 2,000 cc. of air into the esophagus within three to five minutes. It has been shown further that nervous or uncomfortable patients may ingest by these methods up to three times as much air as normal, calm controls. In addition, voluntary belching, which entails the conscious control and use of the superior esophageal sphincter mechanism, may actually introduce more air into the stomach during the initial phases of this act than may be eructated at the completion. This ingested air. whether swallowed or eructated, consciously or unconsciously, may appear at the cecum in six to 15 minutes, and may be passed as flatus within 30 minutes. And unless the mechanism by which the gastrointestinal tract rids itself of gas keeps pace, accumulations of this air may appear in any segment or may fill the tract entirely. *Milton M. Lieberthal, M.D. and H. David Frank, M.D. Gaseous Inflation of the Gastrointestinal Tract. New England J. Med. Nov. 24, 1955.*

‹ ›

Most of life is routine — dull and grubby — but routine is the momentum that keeps a man going. If you wait for inspiration you'll be standing on the corner after the parade is a mile down the street. — Ben Nicholas

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INDEMNITY FOR TOTAL LOSS OF TIME payable for up to
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*"Remember that little bottle you sent me home with?—Well, I'm afraid I overdid it."*

for a spastic GUT

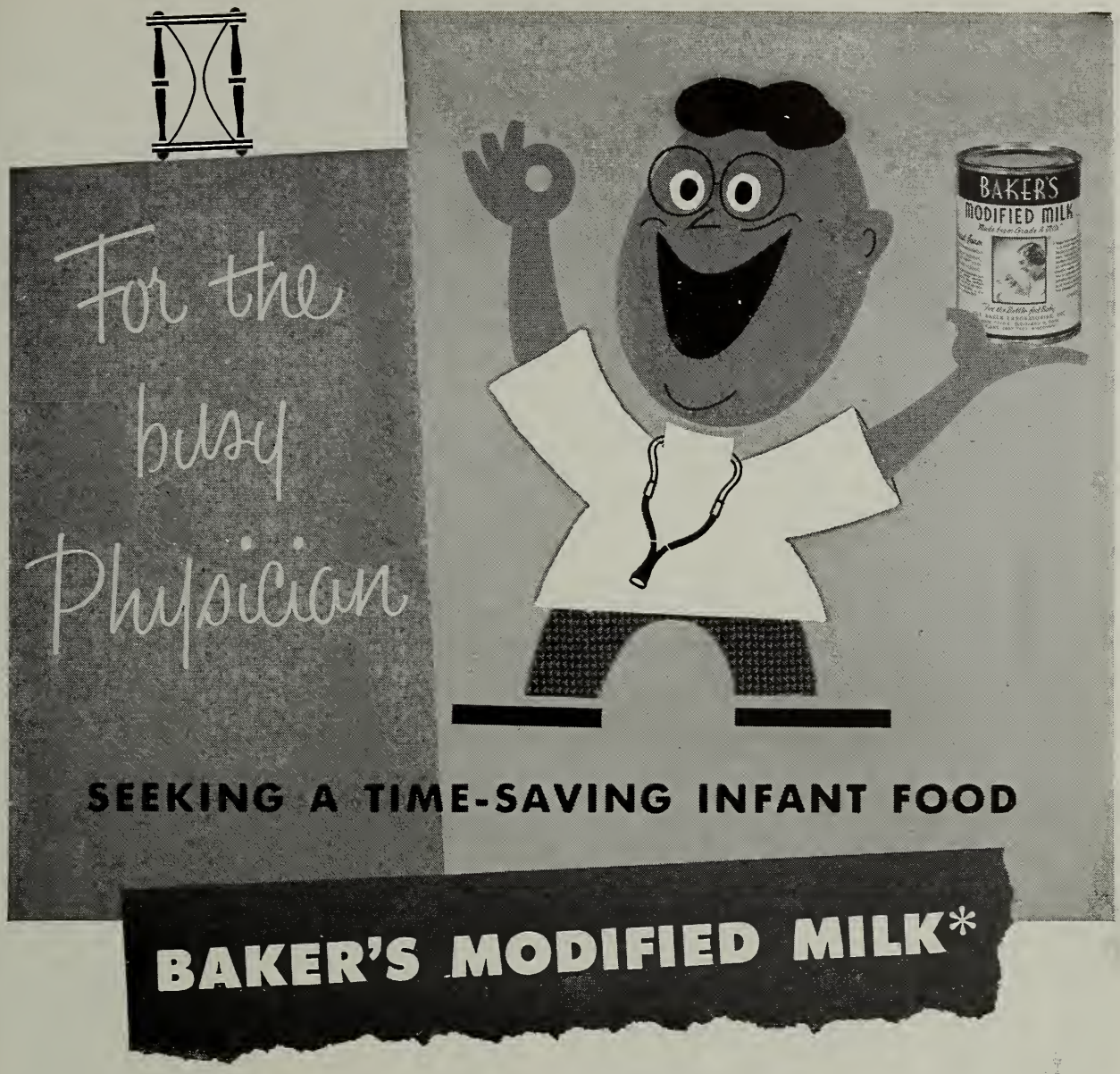
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**FEEDING DIRECTIONS**

*(Normal dilution for liquid provides 20 calories per liquid ounce.)*

| | Baker's | Boiled Water |
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| Hospital | 1 part | 2 parts |
| First week at home | 1 part | 1½ parts |
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Also available in powder form. (Normal dilution one tablespoon to 2 ounces of water provides 20 calories per fluid ounce.

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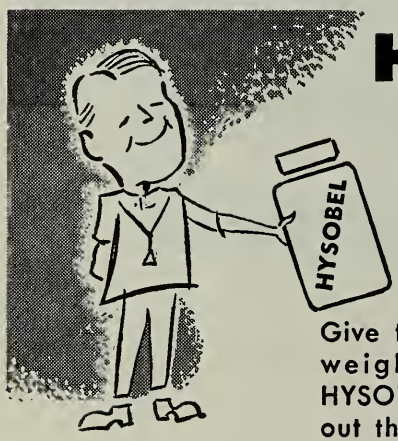
## A record in obstetrics

The survey here reported extends from Feb. 13, 1948, through Aug. 31, 1955. There were 8,002 consecutive deliveries, including cesarean sections without a maternal death. This represents 10,052 obstetric admissions. Every case of an obstetric nature during this period is included for mortality statistics. The survey is large enough and the results are good enough so that it is logical to draw the following conclusions:

The method of practice is fundamentally sound. In group practice you have the advantages of immediate intradepartmental and interdepartmental consultations for all obstetric patients. The importance of having competent and qualified personnel in the field of medicine and maternal nursing is obvious. A comprehensive prenatal program is of vital importance, stressing early prenatal care and the constant search for signs of toxemia. Proper intrapartum management by the obstetrician who is there with the patient during labor should always be provided. Labor is always a risk and deserves constant attention. Caudal anesthesia, either single injection or continuous technique, has proved to be the proper choice of anesthesia. Attention should be given to an intensified postpartum service, stressing constant alertness on the part of physicians and nurses for postpartum hemorrhage and convulsions. Chemotherapy, antibiotics, blood replacement, and conservative methods of delivery are important factors in preventing maternal deaths. A well planned labor and delivery suite with functional units has proved its value. *Leroy F. Ritmiller, M.D. Eight Thousand Consecutive Deliveries without a Maternal Death. Pennsylvania M.J. Dec. 1955.*

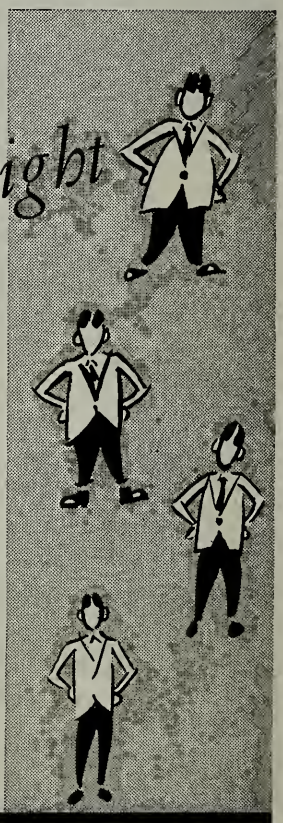
‹ ›

The physician concerned with tuberculosis and diseases of the chest must always be aware of the complications arising from fungous infection of the lungs which may simulate tuberculosis in every degree. Micheal L. Furcolow, M.D., Editorial, Journal-Lancet, April, 1955.


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**Give them the help they need to lose the weight that endangers their health. HYSOBEL. Convenient tablets with or without thyroid and phenobarbital.**

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| Methylcellulose | 0.15 Gm. | (2½ gr.) |
| Thyroid | 15 mg. | (¼ gr.) |
| Phenobarbital | 8 mg. | (⅛ gr.) |

**HYSOBEL NO. 2**

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|---|---|---|
| d-Desoxyephedrine Hydrochloride | .5 mg. | (1/12 gr.) |
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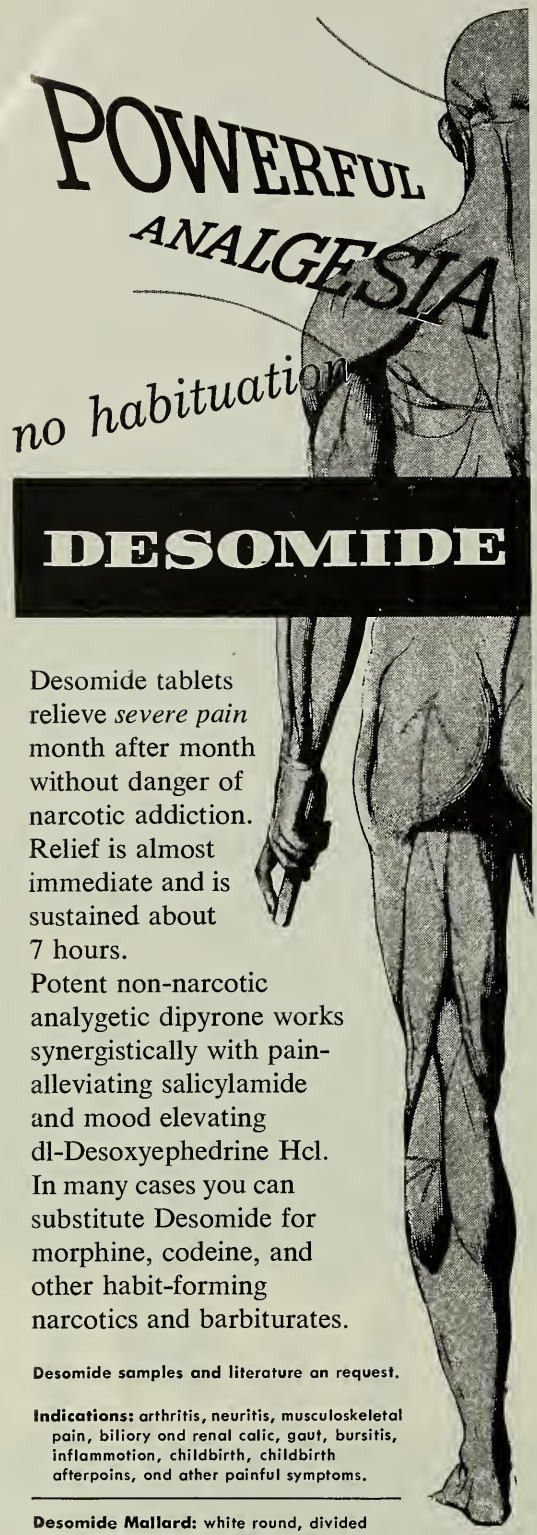
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**Desomide Mallard:** white round, divided toblet contoining Dipyrone 100 mgs., Salicylamide 100 mgs., dl Desoxyephedrine Hcl 1.5 mgs.
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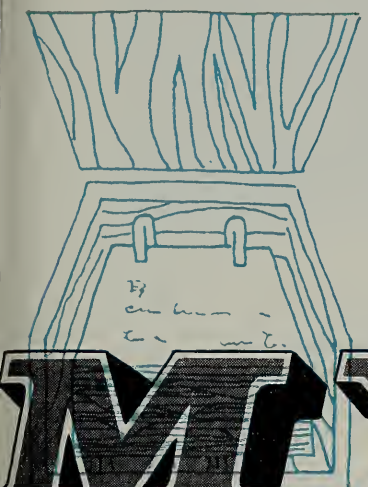
## The cause of myocardial infarction

Myocardial ischemia, ischemia necrosis, and infarction, which are the underlying causes of the clinical manifestations of the acute phase of coronary artery disease, are not due solely to coronary thrombosis. They may result from other acute occlusive processes or from acute functional disparity between the demand and the supply of the blood to the heart muscle. Emotional and/or physical strain are potent factors in the production of the acute phase of the disease. Inasmuch as the condition also may be caused by other known or unknown factors, the following criteria are suggested for establishing causal relationship between physical and/or emotional strain and the resulting cardiac disability or death:

The strain must be severe, and signs of a cardiac insult must follow immediately and must continue. The strain must not necessarily be unusual provided it is great enough and has been undertaken at a vulnerable phase of the disease. The symptoms following the strain must not necessarily be severe soon after, but must be continuous and followed within a reasonable time by evidence of structural myocardial damage. If there was pre-existing cardiac disease, evidence of fresh myocardial injury must be demonstrated soon after the strain. Physically nonstrenuous work, if performed under emotional excitement or upset, may precipitate an attack. Death may occur soon after a given strain, and in the absence of demonstrable acute coronary occlusion at autopsy, is to be attributable to an acute myocardial ischemia due to functional coronary insufficiency, especially when coronary atheromatosis is marked. Delayed death of several years following an acute cardiac insult may

(*Continued on page 74*)

**BELLEVUE PLACE**
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**NERVOUS and MENTAL DISEASES**
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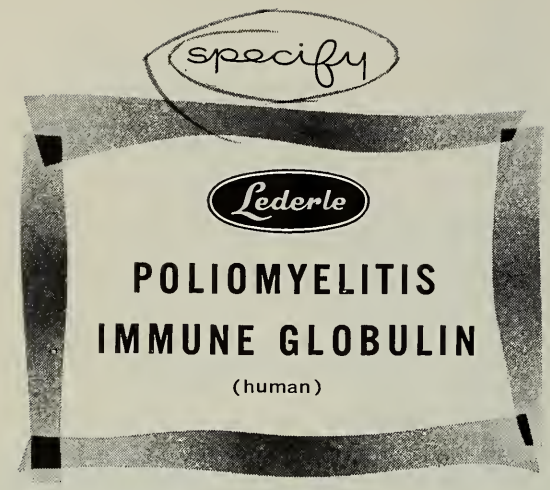
*Each capsule contains:*

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|---|---|
| AUREOMYCIN Chlortetracycline | 250 mg. |
| Ascorbic Acid (C) | 75 mg. |
| Thiamine Mononitrate ($B_1$) | 2.5 mg. |
| Riboflavin ($B_2$) | 2.5 mg. |
| Niacinamide | 25 mg. |
| Pyridoxine ($B_6$) | 0.5 mg. |
| Folic Acid | 0.375 mg. |
| Calcium Pantothenate | 5 mg. |
| Vitamin K (Menadione) | 0.5 mg. |
| Vitamin $B_{12}$ | 1 mcgm. |

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For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

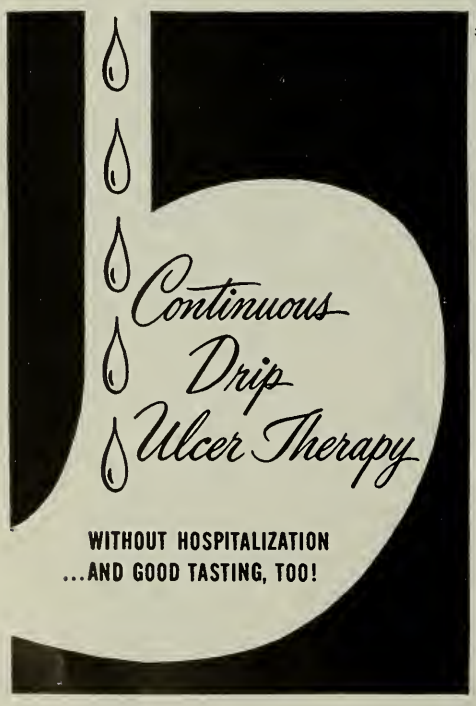
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**MYOCARDIAL INFARCTION (Continued)**

be due to such insult if autopsy findings reveal an extension of the original site of injury, and there are no other acute pathological findings to account for death; otherwise the original injury is not causally related. Repeated attacks of myocardial ischemia, necrosis, or infarction following years after an original injury caused by strain have no relation to the original strain but are part of the progressive degenerative coronary changes. An honest history of the events that precede the cardiac insult is most essential in establishing causal relationship. *Louis H. Sigler, M.D. The Evaluation of Claims for Workmen's Compensation in Cardiac Disability and Death. Indust. Med. Jan. 1956.*

‹ ›

It is the living patients who make up the tuberculosis problem, both as to their treatment needs and the threat they present to perpetuation of the disease. Leo Tepper, M.D., Dis. of Chest, September, 1955.




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A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.



a "judicious combination..."

# for antiarthritic therapy

# SALCORT*

That cortisone and the salicylates have a complementary action has been well established.[1-5] In rheumatic conditions, functional improvement and a sense of feeling well are noted early. No withdrawal reactions have been reported.

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Rheumatoid arthritis . . . Rheumatoid spondylitis . . . Rheumatic fever . . . Bursitis . . . Still's disease . . . Neuromuscular affections

## EACH TABLET CONTAINS:

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| Cortisone acetate . . . . . | 2.5 mg. |
| Sodium salicylate . . . . . | 0.3 Gm. |
| Aluminum hydroxide gel, dried . | 0.12 Gm. |
| Calcium ascorbate . . . . . | 60 mg. |
| (equivalent to 50 mg. ascorbic acid) | |
| Calcium carbonate . . . . . | 60 mg. |

* U.S. Pat. 2,691,662

1. Busse, E.A.: Treatment of Rheumatoid Arthritis by a Combination of Cortisone and Salicylates. Clinical Med. 11:1105 (Nov., 1955).
2. Roskam, J., VanCawenberge, H.: Abst. in J.A.M.A., 151:248 (1953).
3. Coventry, M.D.: Proc. Staff Meet., Mayo Clinic, 29:60 (1954).
4. Holt, K.S., et al.: Lancet, 2:1144 (1954).
5. Spies, T.D., et al.: J.A.M.A., 159:645 (Oct. 15, 1955).

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Dosage: 2 cc. daily.

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| Pyridoxine HCl ($B_6$) | 5 mg. |
| Sodium Pantothenate | 10 mg. |
| Ascorbic Acid (C) | 300 mg. |
| Vitamin $B_{12}$ | 15 mcgm. |
| Folic Acid | 3 mg. |

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## A new concept of cancer

The word "inoperable" no longer carries the notion that the patient is beyond treatment; survival can be prolonged. There are no cures in operable cancer, no estimations of five year survivals, but only control of the disease and Sir Stanford Cade wished to establish a new concept — that cancer should be regarded as a condition similar to diabetes, rheumatism, epilepsy, and heart disease, none of which can be cured but are well controlled by treatment. Palliation of cancer implies the control of the disease by ablation of the symptoms and signs and a return to near normal life. If that also leads to a longer life, then the sting is taken out of the word "inoperable." *Royal College of Surgeons. Lancet, Dec. 17, 1955.*

‹ ›

Public health seeks to have as many persons as possible assume responsibility for obtaining, through their own resources, needed health services. Herman E. Hilleboe, M.D., and Edward R. Schlesinger, M.D., Journal-Lancet, May 1955.

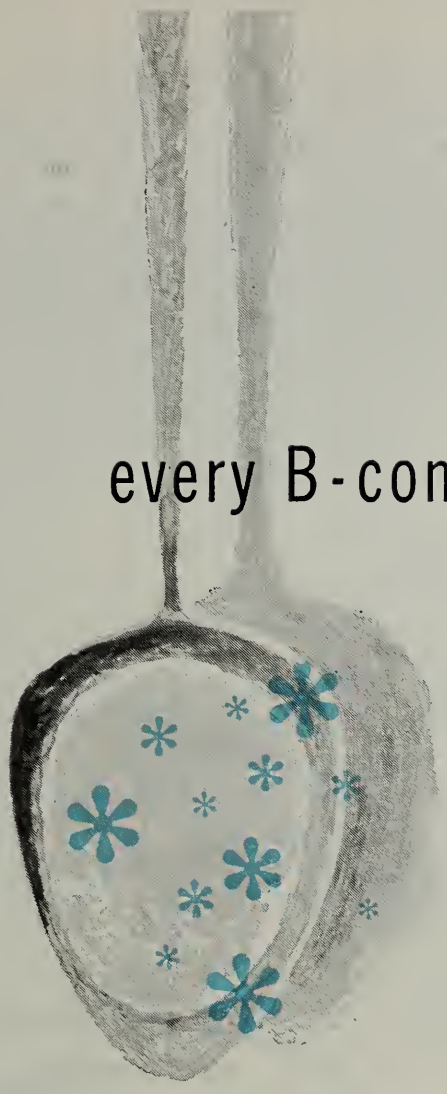
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- Inositol 10 mg.
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A flavor that does not "wear thin" or go "flat" over the prolonged dose regimen necessary with vitamin supplementation.

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The best statistical estimate as to prevalence of tuberculin reactors in the United States is that about one third of our population, roughly 50 million people, are reactors. In other words, about 50 million people harbor virulent human tubercle bacilli which probably will produce active disease at the rate of probably well over 100 new active cases per 100,000 reactors per year. James E. Perkins, M.D., Editorial, Bull. NTA, Jan., 1956.


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Send original articles and membership correspondence to Harold M. Camp. Monmouth, Ill.

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Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.

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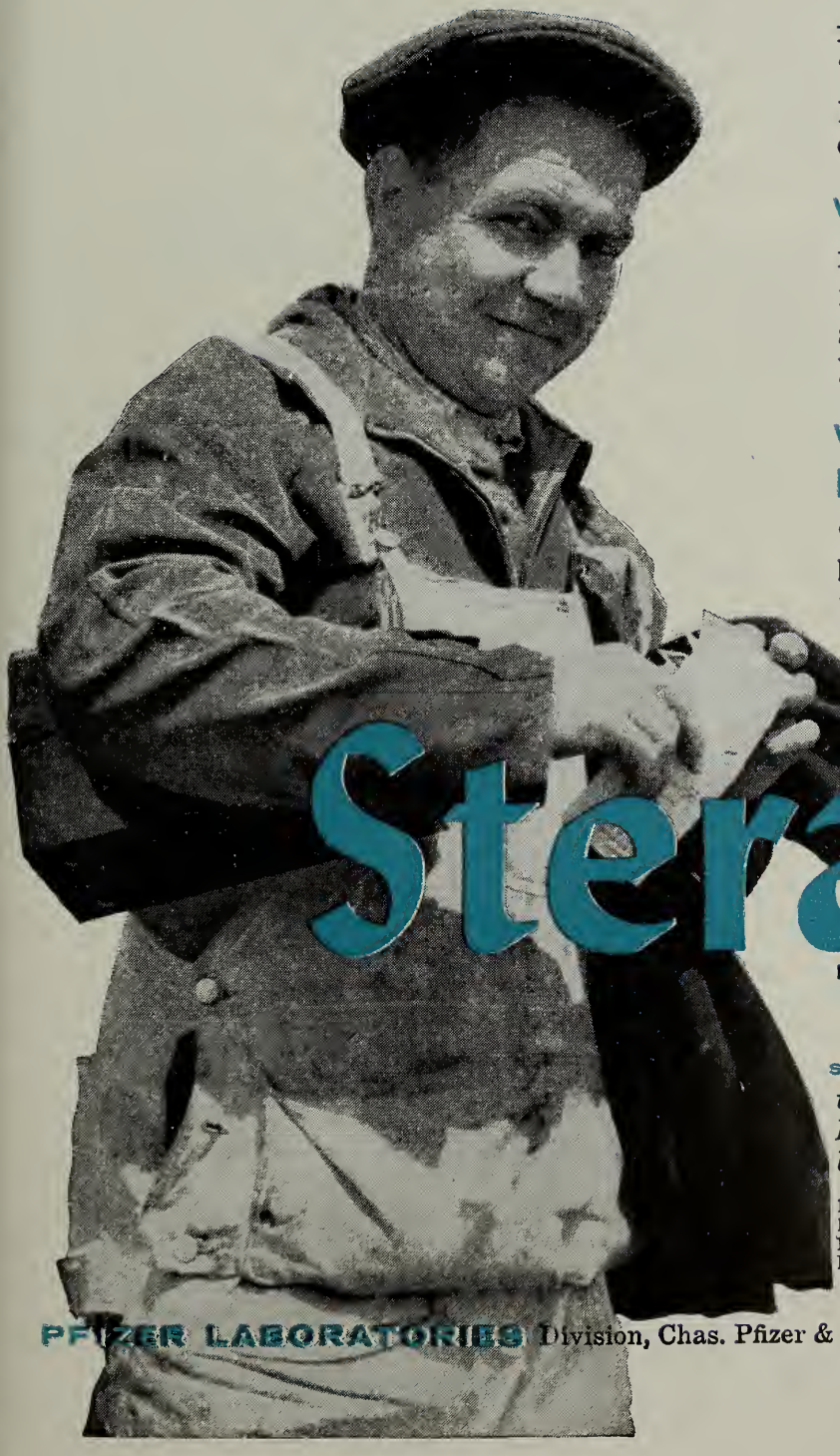
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# The Month in Washington

Washington, D. C.—Among a growing list of health measures receiving active consideration this Congress are two bills that have very good chance of becoming law before adjournment this summer. That both measures have bi-partisan support is an important factor in this election-charged year.

Most advanced in the legislative process, having passed the Senate before the Easter recess, is the national morbidity survey proposal. The other bill, which also originated in the Senate, is the National Library of Medicine plan. Both are indorsed by the Eisenhower Administration.

There has been no national study of the extent of sickness and disability since the rather inadequate survey made in 1936 by the WPA. A series of special and continuing surveys under auspices of the U. S. Public Health Service, accordingly will fill "a very great need," Senator Hill, one of the bill's sponsors, informed the Senate.

Secretary Folsom of the Department of HEW describes the lack of morbidity data as "woeful." Nationwide data on the incidence, cause and duration of sickness and disability are basic, Mr. Folsom has pointed out, to efforts in improving voluntary health insurance.

The Senate agreed and, after writing in an amendment that would assure the conduct of surveys on a non-compulsory basis, the bill passed without a dissenting voice. The measure then went to the House Interstate and Foreign Commerce Committee. The American Medical Association indorses the survey idea.

The National Library of Medicine bill sponsored by Senators Hill and John Kennedy is an outgrowth of one of the Hoover Commission recommendations. The medical task force proposed that the Armed Forces Medical Library be reconstituted as the National Library and placed under the Smithsonian Institution. The Hill-Kennedy bill differs from the Commission in one major respect: it would establish the Library as an independent agency.

Sentiment, meanwhile, has developed for placing the Library in the Department of HEW, under Public Health Service supervision. This was supported by the Administration, and the American Medical Association urged immediate start on construction. Almost two years ago, before the question arose of a National Library, the AMA House of Delegates foresaw the need for housing the Armed Forces Library in more adequate quarters.

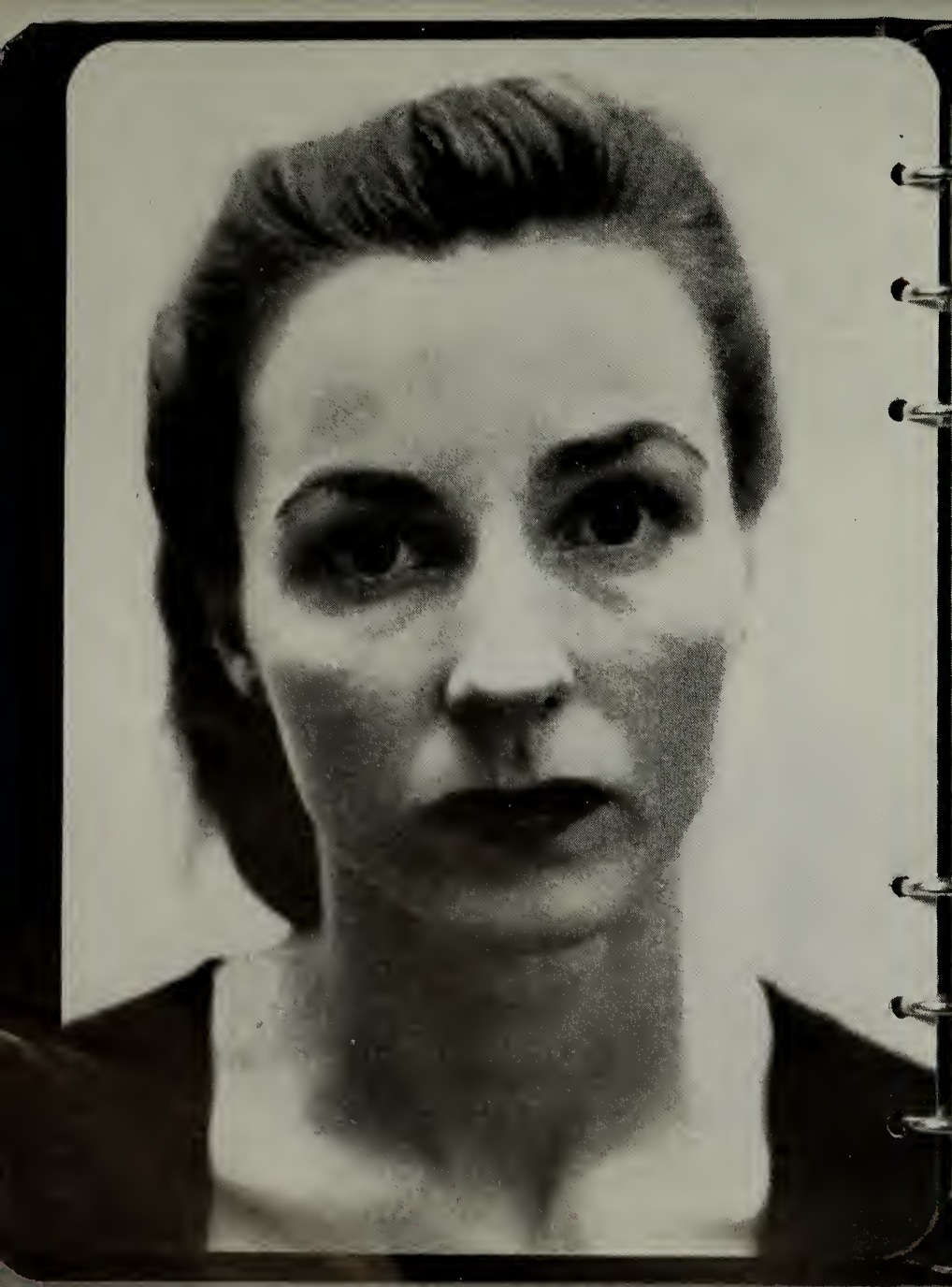
The bill's sponsors pointed out that the AMA in June of 1954 had found that "the irreplaceable collections of the Armed Forces Medical Library are now housed in a 67-year-old building totally unsuitable for the purpose by reason of its inadequate size, poor state of repair, susceptibility to fire hazard and general inadaptibility to efficient operations. . . "

Both Senators made this additional point: so long as it remains in the Defense Department, the Library simply cannot compete for funds against the needs and demands of those activities directly related to national defense.

**NOTES**

A major development in the long legislative

(*Continued on page* 34)



MERATRAN Profile No. 1 **SOCIAL STRESS**

Sex: *Female* Age: *31* Occupation: *Stenographer*
Chief Complaint: *Marked depression.*

Symptoms: *forgetful, bored, depressed.*

Secondary Complaints: *headaches, some disturbed sleep, palpitations, great difficulty in concentration.*

Observations: *this girl is suffering from a reactive depression following the breaking of an engagement.*

Treatment: *Meratran-5mg daily*

Response: *Self-confidence restored, efficiency greatly improved. After 6-week treatment medication dropped. Reactive depression lifted.*

Results: *ambitious, efficient, confident.*

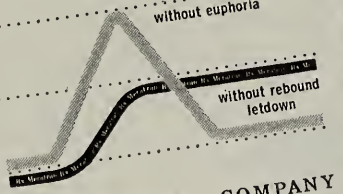
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## WASHINGTON (Continued)

history of the House-approved bill to open up the social security system to cash disability payments was the testimony of Secretary Folsom to the Senate Finance Committee.

In a 3-hour appearance as the 101st and final witness, Mr. Folsom warned against enactment on the disability portion of the bill as well as the plan to lower the retirement age of women from 65 to 62.

Disability payments at age 50, Mr. Folsom declared, present "grave uncertainties" and "potential heavy costs to all social security taxpayers." A majority of the witnesses heard during the extended hearings opposed this section of the bill, H. R. 7225.

On the eve of the launching of the 1956 Cancer Crusade, the Food and Drug Administration issued its first public warning of this type in several years against the cancer treatment fostered by Harry M. Hoxsey. FDA said long and thorough study by it and the National Cancer Institute has produced "no scientific evidence that the Hoxsey treatment has any value in the treatment of internal cancer." FDA said Hoxsey operates clinics at Dallas, Tex., and Portage, Pa.

Surgeon General Leonard Scheele has been confirmed by the Senate for a third 4-year term as head of the U. S. Public Health Service. . . Chairman Priest of the House Interstate and Foreign Commerce Committee has introduced a bill transferring from the Civil Aeronautics Board to the Civil Aeronautics Authority all medical aspects of civil aviation, including pilot examinations. It also authorizes a research program for the proposed Office of Civil Aviation Medicine. . . PHS says the production of the Salk poliomyelitis vaccine is improving. It is now practical, added PHS, for doctors to use their available vaccine for first injections, and to count on receiving new supplies by the time second shots are due. . . PHS Division of International Health, Washington 25, D. C. has a number of openings for physicians in foreign posts.





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The
ILLINOIS
Medical Journal

Official Journal of The Illinois State Medical Society

MAY, 1956
VOL. 109 NO. 5

# Injuries To The Ureter

Norris J. Heckel, M.D., and James H. McDonald, M.D., Chicago

From the time Simon, about 100 years ago, removed a kidney from a patient because of a uretero-abdominal fistula, much has been said and written about surgical injuries to the ureter and bladder. One might well ask why, then, should anything more be said. The reason is that the incidence of ureteral injuries continues unabated and very little if anything is being done about it.

The prevention in most instances is so simple and the treatment many times so difficult that one wonders why the prevention is not more frequently emphasized.

Sisk, at the Wisconsin General Hospital some twenty years ago stressed the necessity for the preoperative insertion of ureteral catheters in all patients undergoing pelvic operations as a means of preventing ureteral injuries. He emphasized the point that no surgeon can predict when a simple operation may become difficult at some stage of the procedure.

According to Moore, the incidence of ureteral injuries as a complication of all operations on the female genital organs is from 1 to 3 per cent. The proportions of unilateral to bilateral ureteral injuries is about 6 to 1. They can and do occur in the hands of the most skilled surgeons.

*From the Department of Urology of the Presbyterian Hospital of Chicago and the University of Illinois College of Medicine.*

*Read at the Sectional Meeting of the American College of Surgeons, January 17, 1956, Jacksonville, Florida.*

## CAUSES

The common surgical procedures that may injure the ureter are ligation, clamping, partial or complete division, resection and occlusion or tears from closely applied sutures. Occasionally the ureter may be punctured by a catheter or bullet (Figure 1).

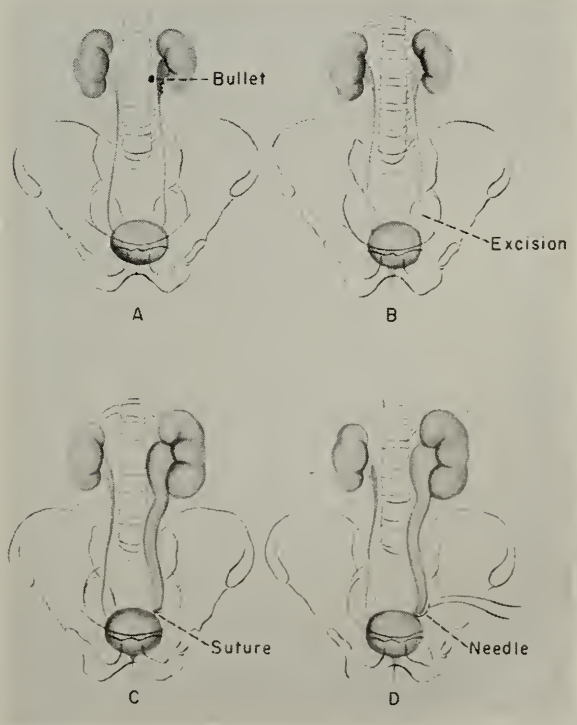



Figure 1.—An illustration of four types of ways a ureter can be damaged.

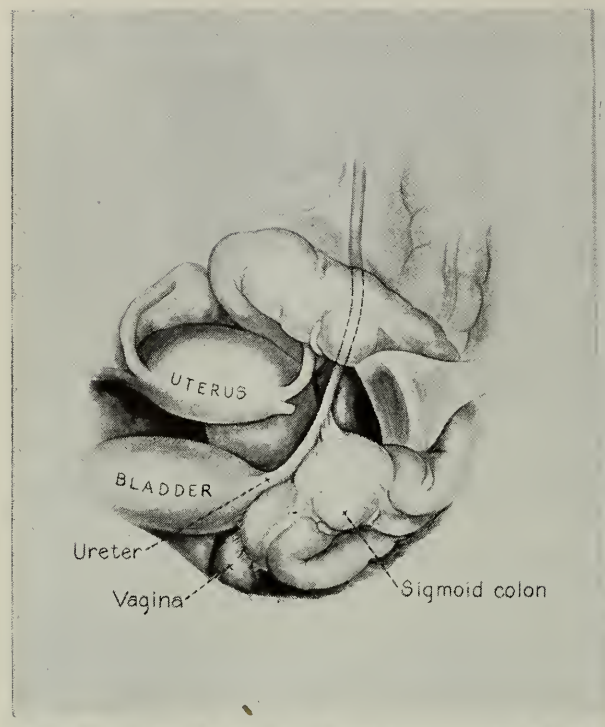



Figure 2.—A vesico-vaginal, uretero-colonic fistula.

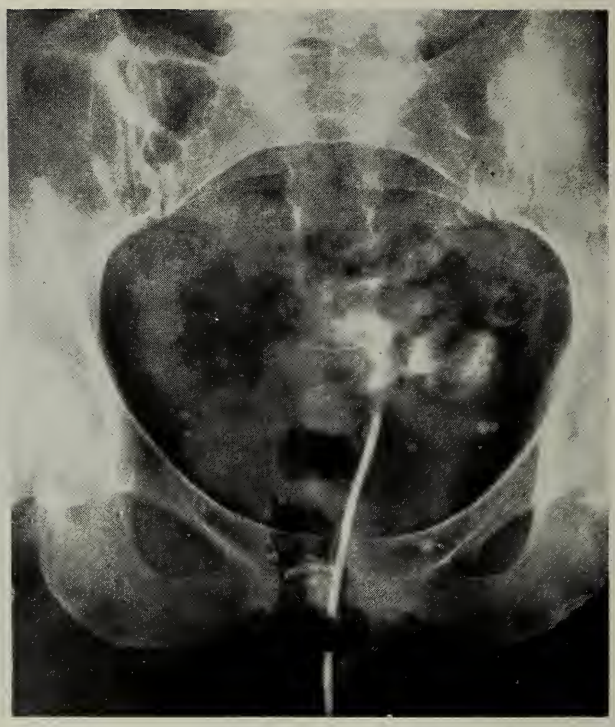


Figure 3.—A cystogram on the patient shown in Figure 2. Note contrast media in bowel following injection of solution into bladder.

## TYPES OF OPERATIONS

The most frequent types of operations in which the ureter may become involved are the various methods of performing a hysterectomy (Figures 2 and 3), such as abdominal, vaginal, supracervical or radical; abdominal-peritoneal resection, salpingo-oophorectomy, vesical diverticulectomy and transurethral resection of the prostate gland.

## PATHOLOGIC CHANGES AND PATHOLOGICAL ANATOMY

The common results of complications of injury to the ureter can be divided into two groups,—namely, local and renal. Under the local pathological changes that can develop are stricture, infection and fistula. In the upper urinary tract hydronephrosis, pyelonephritis or atrophy usually occurs if the injury is not immediately recognized. On the other hand, the two most common conditions that follow such an injury are uretero-vaginal or uretero-abdominal fistula.

If the ureter is completely and permanently occluded, suppression of urinary excretion with hydronephrotic atrophy of the kidney develops. The destruction of kidney tissue is in direct proportion to the length of time of the ureteral occlusion. In all probability the damage to the kidney in complete occlusion is irreversible after 15 to 20 days.

If there is only partial occlusion of the ureter the pathological changes are characterized by dilatation of the ureter, pelvis and calyces. The amount of dilatation is in direct proportion to the amount of occlusion. Because of the stasis, pyelonephritis usually develops.

If the ureter is partially or completely divided there is a retroperitoneal extravasation of urine with tissue necrosis. In the course of some operations, surgeons have found it necessary to ligate and cut one ureter with the feeling that there would be no severe consequence. Such a procedure should be avoided if possible because the kidney rapidly undergoes hydronephrotic atrophy and usually infection results.

## SYMPTOMS

*Unilateral Complete Occlusion*: If the ureter is completely ligated in the course of an operation, the symptoms may be so mild that the condition is not recognized. In some instances, however, kidney pain with the signs and symptoms of renal infection on the occluded side will call attention to the complication.

*Bilateral Complete Occlusion*: If both ureters are completely occluded, the early symptoms are nausea, vomiting, renal pain and anuria. In 24

to 48 hours the patient will begin to develop the signs and symptoms of renal insufficiency. If renal function is not restored in a short period of time, death occurs.

*Bilateral Or Unilateral Resection Or Partial Division Of Ureter*: In this group of patients the symptoms are those of retroperitoneal extravasation of urine, abdominal distension, fever, chills, vomiting, hiccoughs, with all the signs and symptoms of shock. The prognosis is in direct relationship to the duration of the extravasation.

## DIAGNOSIS

When the injury or damage to the ureter is immediately recognized the diagnosis is obviously made and the only problem at the moment is the repair of the ureter or ureters. In the patient where the condition has not been recognized at the time of the operation the diagnosis is made from a well organized plan of procedure.

If the postoperative course of a patient who has undergone a pelvic or lower abdominal operation presents symptoms that are the least unusual an injury to the ureter should at least be considered.

The two important and reliable diagnostic procedures are excretory urography (Figure 4), and cystoscopy with ureteral catheterization.

If there is a complete ureteral occlusion there will be no excretion of dye on the occluded side. If both ureters are occluded there will be no excretion of dye. If there has been a puncture, a tear, a partial or complete resection of the ureter, an extravasation of the dye will occur at the site of the ureteral injury.

I do not know of any definite contraindication for the use of this important diagnostic procedure. Fever is not one. It is well to bear in mind that the majority of injuries that occur to the ureter are located within 6 cm. of the bladder.

## TREATMENT

*Prevention*: The pelvic ureter which is from 6 to 8 cm. long has a tendency to deviate from its so-called normal anatomical course. In other words, normal variations are common. Add to this fact the effect that such pathological conditions as pelvic tumors, abscesses and inflammatory processes has upon its course, it is surprising that ureteral injuries are not more common. The preoperative use of ureteral catheters is probably the one big thing that will reduce the incidence of ureteral injuries. I know of no harm or complications that result if soft ureteral catheters are used. The infrequency with which they are used is in all probability due to false pride.

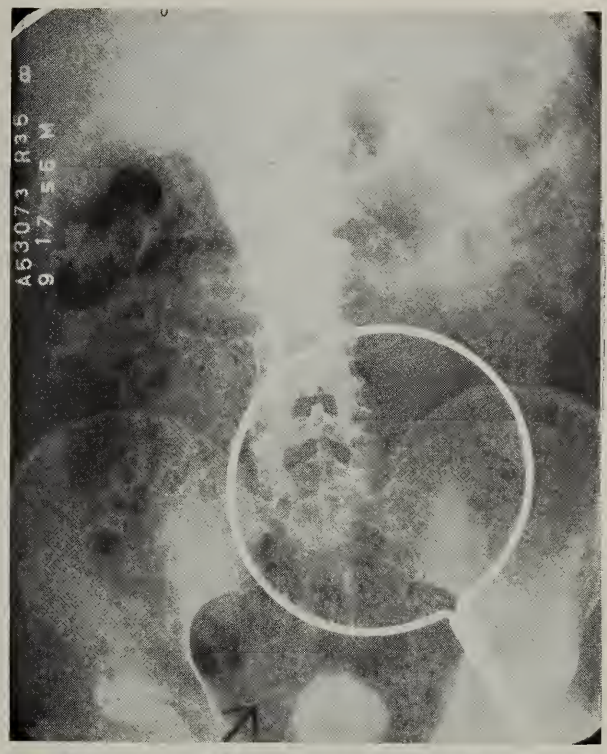



**Figure 4.—Diagnosis of urinary extravasation made from excretory pyelogram. Note presence (arrow) of dye in retroperitoneal space.**

The basic principles that should always be kept in mind and which play an important part in the treatment and prognosis are:—early recognition, diversion of the urinary stream, adequate drainage (even though we have potent antibiotic drugs) and repair of the defect. Individualize the problem as each case of ureteral injury is an individual problem and for each problem there is a good operation. Conservation of renal tissue, however, should not be done at the expense of good surgical judgment. Many times a desperate attempt is made to save the kidney only to remove it later. Avoid fancy and complicated operations. Remember, it is far better to resort to two operations, if necessary, and have a live patient than to do a beautiful, fancy, technical operation and have a dead patient. If there is any question, divert the urinary stream and quit. In injuries without extravasation all that is necessary in many instances is the insertion of an indwelling ureteral catheter, bed rest and antibiotics.

### COMPLETE URETERAL OCCLUSION

If bilateral, then the safest procedure is to do either a bilateral pyelostomy or nephrostomy. Remember, these patients are very sick and usually in some degree of shock. After the patient has completely recovered from the original operation the obstruction in the ureter can be localized by ureteral catheterization and the defect repaired. However, do not remove the pyelostomy or nephrostomy tubes until you are sure you have successfully corrected the occlusion. After the 8th to 10th postoperative day clamp off the tubes first and see if you have obtained a good functioning result.

In unilateral occlusion the problem is not so grave. If it is recognized early and the patient is in good condition, an attempt can be made to reestablish the patency of the ureter. However, if the patient has had a long operation then either a pyelostomy or a nephrostomy should be done and the repair to the ureter carried out later.

### RESECTION OF ONE OR BOTH URETERS

If there has been a severance of one or both ureters which has not been recognized at the time of operation the course of action should be an immediate diversion of the urinary stream as soon as the extravasation is recognized. This can be done by a pyelostomy or nephrostomy*. Usually these patients are extremely sick, especially if the extravasation has been present for over 24 hours. Careful postoperative care, such as electrolyte balance and antibiotic therapy is absolutely necessary. No attempt should be made to reconstruct the ureter or ureters for at least 3 or 4 months.

*In our experience a number 20 Foley catheter with a 5 cc bag are ideal for pyelostomy or pethrostomy tubes.

### CONCLUSION

1. The incidence of ureteral injuries as a complication of major operations on the lower abdomen and pelvis has not diminished.

2. The preoperative insertion of ureteral catheters will prevent the majority of such injuries.

3. The treatment of any ureteral injury is an individual problem.

4. If there is any question on what to do, divert the urinary stream and repair the injury at a later date.

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# Recent Advances in Exfoliative Cytology

ELIZABETH A. McGREW, M.D., CHICAGO

THERE have been several developments of interest in the field of exfoliative cytology in the last few years. In response to a widely felt need for an integrative body and a common ground on which workers in various clinical, laboratory, and research fields might meet to exchange and discuss ideas, the Inter-Society Cytology Council was formed in 1951[1]. Its membership includes pathologists, gynecologists, gastroenterologists, urologists, general surgeons, M.D.'s, Ph.D.'s, and technicians. Its second annual meeting last fall consisted of a two day program, from which much of the material to be presented in this report is derived.

The value of the Papanicolaou method of preparation, staining, and examining smears of body secretions has been firmly established in the last 10 years in relation to the detection of malignancy. There is now no doubt that the addition of cervical smears to gynecologic examination increases the detection rate of uterine cancer by about 17 per cent in routine practice and by at least 50 per cent in the examination of asymptomatic women[2]. The increment in lives saved relates to the fact that most of these carcinomas are discovered in stage 0 or stage I, in which curability is highest. When cervical smears are properly obtained and expertly interpreted, the method is 98 per cent accurate.

It is common practice, when smears are positive in the absence of a visible lesion of the cervix, to perform a deep conization biopsy of the entire circumference of the cervical os. This biopsy alone may be sufficient treatment for pre-invasive carcinoma of the cervix if the pathologist, by serial sections, can certify that no invasion has occurred and if the patient can be followed carefully by smears every few months thereafter[3]. It is now clear that women with suspicious smears should be followed, even though biopsy is negative, and that the character and type of the cells on the smears can help to determine whether biopsy should be repeated, bottom of the tube, while the tumor cells and where the biopsy should be taken, and how closely the case must be followed.

In other areas of the body the accuracy of cytology varies, since sufficient numbers of well preserved cells may be difficult to obtain. Positive smears from the bronchus, for instance, indicate at least a 98 per cent chance of bronchogenic carcinoma and, together with an X-ray shadow, are considered indication for thoracotomy, even without a positive biopsy. False negatives are numerous in lung material in our experience, however, because of the difficulty of obtaining sufficient cells. In the stomach, too, there are many false negatives, but a positive smear may help to evaluate cases with equivocal X-rays. The cells of carcinoma of the urinary bladder, ureter, and pelvis are found fairly consistently in urinary sediment and may aid in the diagnosis of carcinomas masquerading as inflammatory conditions of the bladder or located higher in the urinary tract. Prostatic secretions yield cells sometimes, especially early, when other means of detecting the lesion are more difficult.

The recent extension of exfoliative cytology to the detection of malignancy in more remote areas, such as the kidney,[4] colon, central nervous system, pancreas, and biliary tract has led to the development of special techniques to obtain and process material. The abrasive gastric balloon[5] is a large balloon attached to one lumen of a double gastric tube and covered by a coarse netting of the type used for hat veiling. The balloon is inflated in the stomach and carried to the pylorus by peristalsis several times, being pulled back to the cardia each time. The number and quality of cells obtained from the interstices of the netting on removal is more satisfactory than with lavage.

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*From the University of Illinois College of Medicine*

*Presented before the Section on Pathology, Illinois State Medical Society, 115th Annual Meeting, May 18, 1955*

To improve the quality of smears from the endometrium a small cannula may be used to aspirate secretions directly from the uterine cavity[6]. Isotonic saline enemas[7] and duodenal intubation[8] are helpful in obtaining material from the colon, biliary tract, and pancreas. Malignant cells may be separated from bloody or purulent effusions by centrifugation of resuspended sediment layered onto a moderately concentrated bovine albumin solution. The red blood cells and debris are thrown down to the bottom of the tube, while the tumor cells and histocytic elements float on the albumin solution.[9]

To solve some of the problems of processing large numbers of smears in cancer detection work, Mellors[10] in 1951 devised a mircofluorometric scanner, which is now being used experimentally. A smear stained with a nuclear fluorescent dye is moved back and forth automatically on the stage of a microscope. An ultraviolet light source causes fluorescence of the chromatin in the nuclei and a sensitive photoelectric cell at the eyepiece of the microscope is attached to recording and counting devices. The normal smears with no large or hyperchromatic nuclei are thus eliminated and careful screening and evaluation by the human eye would be necessary only for those indicated by the machine as containing atypical or abnormal nuclei. No reports as to the accuracy of this machine in terms of false negatives are available as yet.

A variety of methods, such as phase microsopy, silver stains, and fluorescent dyes, are being used to identify malignant cells. These methods rely, as does the Papanicolaou stain in part, on the visualization and rough quantitation of nuclear chromatin. Cytochemical methods for staining types of nucleic acid and various enzymes also are being explored and may have important applications.

Purposes other than detection of malignant disease also are served by cytologic techniques. In research on the fundamental nature of the neoplastic process this type of material furnishes an opportunity for the study of progressive changes in cells during the development of human and experimental neoplasms, and their reactions to environmental changes. Reagan[11] has studied smears and tissue sections in 100 women with "atypical epithelial hyperplasia" of the uterine cervix. This lesion is characterized by moderate nuclear enlargement and hyperchromasia, hypercellularity, and parakeratosis. In the cervical smear there is moderate enlargement and irregularity of the nuclei, constituting a mild degree of what Papanicolaou has called dyskaryosis. Reagan was able to keep track of 65 of these women, nine of whom developed carcinoma in situ and one, invasive carcinoma. The smears became normal following biopsy in 35 of the patients and the lesion persisted in about the same degree of atypia in 20. Nieburgs has observed 23 patients in whom mild dyskaryosis in smears progressed to carcinoma in situ in one to three and one-half years.

These reports of serial biopsies and Papanicolaou smears from women with borderline cervical lesions have demonstrated the wide range of insidious morphologic changes leading to true malignancy. The least dyskaryosis in smears occurs in squamous metaplasia or reserve cell hyperplasia of the cervix. Changes are more marked and atypical cells more numerous in so-called dysplasia, atypical epithelial hyperplasia, or basal cell hyperactivity. The atypical cells are most numerous and their abnormalities more marked in carcinoma in situ of the cervix. Foraker[12] is studying enzyme systems in an attempt to correlate changes in these with hyperplastic, pre-invasive, and invasive lesions.

Smears of cervical secretions also may be used to evaluate endocrine states, not only by the study of the cell types[13] but also by the crystallization pattern of cervical mucus dried on a slide[14]. In sterility problems, pregnancy, abnormal bleeding, and in guiding hormone therapy, the estrogen level may be estimated by the percentage of cornified cells and progesterone effect recognized by the clumping and wrinkling of squamous cells. Vaginal smears may also give warning of abortion[15] as cells from the parabasal layer of the vaginal and cervical mucosa are more numerous than in normal pregnancy.

The work of Graham[16] in evaluating the response to radiation of carcinoma of the cervix is among the most interesting reported. Serial smears, taken during radiation therapy for carcinoma of the cervix, show a progressive degeneration and disappearance of malignant cells in most cases. Less often, the normal vaginal

epithelial cells show radiation damage, reaching a peak ten days to two weeks after the beginning of therapy. These changes consist of vacuolization of the cytoplasm and nuclei, nuclear enlargement, and the development of large squamous cells, often with double nuclei.

Graham counted the radiation-damaged normal cells in 142 patients treated for carcinoma of the cervix and divided them into two groups. Those whose smears displayed radiation effect in 75 per cent or more of the normal cells were considered to show a good response to therapy, while those with radiation changes in 60 per cent or less of their normal cells were considered to show a poor response. Fifty-five per cent of the good response group were free of disease after five years, while only 8 per cent of the poor response group were alive (Table 1). This apparently provides a reasonably accurate means of predicting which patients will not be cured by irradiation of carcinoma of the cervix. It affords the clinician an opportunity to improve by surgical means the five year survival rate of carcinoma of the cervix, now only 38 per cent.

TABLE 1
RADIATION RESPONSE AND SURVIVAL IN CERVICAL CARCINOMA (GRAHAM)

| | Number | Number surviving 5 years | Per cent surviving 5 years |
|---|---|---|---|
| Good response | 77 | 50 | 56% |
| Poor response | 65 | 5 | 8% |
| Total | 142 | 55 | 38% |

Attempts to find a single criterion for predicting radio-curability disclosed that the degree of normal cell enlargement alone corresponds fairly well with radiation damage counts and five year survival[17].

Smears taken before treatment is begun also contain features related to curability. It was found that if cells from the parabasal layer of the epithelium constituted 20 per cent or more of the normal cells, the response to radiation was better than if the smears contained less than 9 per cent basal cells. While this is of theoretical interest, it is not so accurate a means of predicting radiocurability as the study of the cells after radiation is begun. However, Graham has described a specific alteration of the parabasal cells in the pretreatment smears which she calls the SR (Sensitivity Response) phenomenon. This cell has deeply basophilic and finely vacuolated cytoplasm. When patients are divided into two groups on the basis of the number of SR cells in pretreatment smears, 73 per cent of those who had 10 per cent or more SR cells are well after five years and only 5 per cent of those who have fewer SR cells are alive.

Some suggestive points arise from this material. First, radiosensitivity or resistance is not a property of the tumor alone but also of the host tissues since the visible effect on normal cells is a better index of curability than disappearance of tumor cells. Second, this property is lost as the tumor grows, the cells of patients with stage I carcinoma showing a good response in 13 of 15 cases; but in stage IV carcinoma, only four of 17 patients had cells which were sensitive (Table 2). Graham considers that the SR phenomenon and the capacity of normal cells to respond to radiation indicate a transient phase of high host resistance to the tumor and greater radiosensitivity. As this is lost, the patient becomes refractory to radiation and the tumor spreads rapidly.

TABLE 2
RADIATION RESPONSE AND SURVIVAL IN CLINICAL STAGES OF CERVICAL CARCINOMA (GRAHAM)

| | Number with good response | Per cent surviving 5 years | Number with poor response | Per cent surviving 5 years |
|---|---|---|---|---|
| Stage I | 13 | 69% | 2 | 0% |
| Stage II | 45 | 78% | 24 | 3% |
| Stage III | 15 | 40% | 26 | 2% |
| Stage IV | 4 | 0% | 13 | 0% |

From a practical standpoint, the evaluation of radio-sensitivity is time consuming and Graham's criteria for recognizing damage are difficult to apply. However, the possibilty of improving the salvage rate in cervical carcinoma by the use of modified or additional therapy for patients with poor radiation response has stimulated the interest of pathologists and clinicians alike. A few workers, here and in Europe, have been able to corroborate Graham's results and Glucksmann[19] in England has obtained comparable results by studying serial biopsies during therapy. In tumor tissues, the prediction of radiocurability is based on the amount of necrosis and mitotic abnormality as radiation progresses.

More recently, attempts to correlate radiocurability with the replacement of desoxyibose nucleic acid by ribose nucleic acid in radiated tumor cell nuclei have been initiated[20].


## SUMMARY

Recent advances in exfoliative cytology have been briefly reviewed. The formation of the Inter-Society Cytology Council has facilitated exchange of information and ideas. The value of the cytologic method has been established, particularly in screening for cancer of the female genital tract and as an adjunct in the identification of malignant tumors of the respiratory, gastrointestinal, and urinary tracts. Extension of the method to the detection of malignant disease in other areas is progressing. Special techniques of obtaining and processing material have been developed, including an electronic scanner for processing large numbers of smears. The application of cytologic techniques as a research tool has broadened our understanding of tumor development. Graham has described changes in normal cells during radiation therapy for carcinoma of the cervix which are specifically related to the curability of the lesion. This work is important in terms of improving the salvage rate in carcinoma of the cervix.


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## Insomnia in the aged

Dr. Erlandsson (chief medical officer of Sweden's first home for the aged at Sabbatsberg) says that sleeplessness is a big problem among older people. He rarely uses phenobarbital or other sedative because it makes old people thrash around and fall out of bed and has bad after effects. He thinks part of the trouble at night comes from slowed circulation in the brain and the extremities which occurs when a person lies down, so he gives brandy or two or three cups of coffee before bedtime to stimulate the circulation. There are less heart pain and cramps in the legs at night and more peace and quiet on the ward with such simple therapy. *Herman E. Hilleboe, M.D. Geriatric Services in Denmark, Norway, and Sweden. Geriatrics, Nov. 1955.*

# Hypothermia in Surgery for Major Vascular Graft

**Paul W. Searles, M.D.*, Max S. Sadove, M.D.**, and Ormand C. Julian, M.D.**, Chicago**

WE will present our technique for anesthesia in vascular grafts. This group of cases presents varying degrees of vascular degenerative disease. In some, the condition is localized but more frequently it is generalized. Many have coronary vascular disease, hypertensive cardiovascular disease, old coronary infarcts, and varying degrees of vascular occlusion as well as the many other diseases found in a cross section of patients of this age group. Some of these cases were elective; others, acute emergencies.

Our discussions will be limited to the management of patients in whom a graft of a major vessel was attempted and accomplished. It must be emphasized that in this type of surgery an efficient, well- co-ordinated team is essential. Teamwork between surgeon and anesthetist in the operating room is vital in the management of these patients. Each must understand the problems of the other and be willing to subjugate his will for the benefit to the patient since he, in the final analysis, is the primary factor in all surgery.

## PREPARATION OF PATIENT

In view of the fact that these cases and operations are in general rather severe traumatic surgical procedures they must be investigated and worked up as befits the type of surgery contemplated. This work-up must include careful evaluation of the patient's cardiovascular-pulmonary function and such tests must be carried out as indicated by the preliminary, careful routine physical examination. These patients need more intensive evaluation of their cardiac status and renal status and their pulmonary and vascular function. They must be in as good a compensation as possible in the time permitted. Diuretics, cardiac glucosides, and hypotensive drugs may and should be used when indicated. Blood volume should be adjusted as indicated by the physical examinations. Preoperatively, these patients should be taught how to cough as well as deep breathing exercises. It should be explained to them that they will be required to breathe deeply and turn from side to side and that there may be a small amount of pain. They should be prepared psychologically for this operation. When indicated, bronchodilators, antibiotics, detergent aerosols, and pulmonary and coughing exercises should be utilized to diminish the possibility of postoperative pulmonary complication which could be so disastrous in this group of patients.

The objectives of this technique may be enumerated into 13 major points.

1. The induction should be smooth and rapid, without wasted time. There must be no fall in blood pressure nor cardiovascular strain that might lead to a vascular accident.

2. The technique should be such that the patient can be maintained with minimal amounts of anesthetic drugs. Only drugs necessary for the maintenance of the technique should be used and in the amounts necessary for the individual technique. The more types of drugs used, the more confusing the technique and the more chance for error. However, by the proper blending of various drugs, the patient can be maintained in a much more ideal state of anesthesia.

3. During this procedure, the blood pressure should be controlled by the anesthetist so that when he desires, he can lower it. At the same time an adequate circulation is needed which is vital to this group of patients who have some form of vascular insufficiency.

4. Oxygenation of the patient must be adequate. Even a short period of oxygen inadequacy may lead to disastrous results.

5. As in all patients, carbon dioxide must be eliminated efficiently. This is one of the most insidious problems in anesthesia, especially in those cases involving intrathoracic vascular procedures.

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*Presented before the Section on Anesthesiology, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

6. The temperature of these patients must be adequately controlled. One should have the ability to attain the temperature desired at the time of occlusion of the major vessel and yet be able to hold it above levels that may be hazardous to the patient and start it back towards normalcy at the end of the procedure.

7. The temperature must be known to the anesthesiologist at all times.

8. These patients must be carefully watched and undue stress avoided by the combined effects of surgery and anesthesia.

9. The blood pressure at the end of the procedure as well as during the procedure must be adequate so that the adequacy of the circulation can be recognized. Frequently, because of the extensive disease in these individuals, multiple pathology exists and anastomosis may be done at a high level only to have a thrombosis occur at a lower level. Hence the procedure should be such that thrombosis or obstruction of flow can be recognized at any time during the procedure.

10. The patient must be so controlled so that as the last sutures are being placed, one begins to see emergence phenomena. This is important in that the possibility of cerebral vascular accident is much higher in many types of surgery in and about the arch as well as in many patients with marked fluctuations in blood pressure due to occlusion or rapid loss of blood.

11. A hypotensive state must be produced so that when the clamp is placed across the major vessels, the pounding of the blood pressure against the wall of the vessel in the immediate vicinity of the clamp will not injure the vessel. This is especially important where the vessel has thinned out to such a degree that rupture is imminent.

12. A state of hypothermia is needed as well as other physiologic depression so that the major vessels of the body may be clamped for long periods of time during anastomosis. In some instances we have had large vascular trunks occluded for as long as an hour and 20 minutes.

13. Adequate infusion systems with large bore needles (#15 and #16) must be in place so that blood can be replaced as rapidly as it is lost.

## ANESTHETIC TECHNIQUE

We will now present our average management for so-called average case. However, we wish to point out that this technique varies, dependent upon the physiologic needs of the patient. In most instances, premedication consists of 50 mg. Demerol® and atropine sulfate .4 mg. three-quarters of an hour before the patient is expected in the operating room. When the patient arrives in the operating room, he is then given either Phenergan® or Thorazine® alone or in combination. Recently, we have begun to prefer the combination to Thorazine alone. However, it must be pointed out that the Thorazine rarely is given in the large doses suggested by some. In almost no case have we ever in recent times exceeded 35 mg. The usual procedure is to give 5 mg. well diluted over a 2-2½-3 minute period and then add 5 mg. at a time every five to 15 minutes until the dosage is felt to be adequate.

Phenergan, however, can be given early in the operative procedure prior to or shortly after the induction in doses as large as 25 to 50 mg. in a single injection. Here also Phenergan should be diluted approximately 25 to 50 mg. in 10 cc. of normal saline. In this way there will be relatively little change in blood pressure or pulse; in fact, with Phenergan we often see a relative bradycardia. When blood pressure is low, we increase Phenergan and diminish Thorazine or omit it entirely. Above all, small doses must be used, carefully observing its effect and its combined effect with the anesthetic agents.

When the patient first arrives in the operating room, a small amount of a local anesthetic is injected into a leg and an intravenous infusion is started with 15 or 16 gauge needle in one of the major leg veins. The solution used is prechilled 5 per cent dextrose. The intravenous infusion, once it is functioning, must run freely without dropping. In most instances, the anesthetic is started with Pentothal® and dimethyl d-tubocuraine. Usually 2 syringes are used, one containing a 2½ per cent solution of Pentothal in 20 cc. of normal saline. The second syringe, 10 cc., contains approximately 5 to 7½ mg. of dimethyl d-tubocuraine. At times, however, both drugs are combined in a single syringe containing 500 mg. Pentothal and 7 mg. dimethyl d-tubocuraine. Five cc. of this mixture is injected fairly rapidly and the patient watched carefully for signs of reaction to this test dose. The rest may be added gradually, based upon the

patient's overall reaction to the drug as it is injected. This dosage is carefully selected based on the overall physiologic state of the patient. The syringe and needle are not withdrawn from the tubing but rather kept in place ready to give additional doses should it be necessary.

During this induction, oxygen is given to the patient and as respiration is depressed, the respiration gradually becomes assisted and full control of the respiration may be taken should it become unduly depressed. Once relaxation is adequate, color is good, and pulse is slow, the patient is quickly intubated with a cuffed endotracheal tube. This tube is quickly connected to the anesthetic machine. Respiration is then either assisted or controlled but above all there should be no bucking on the tube. The anesthetic agent should not be added rapidly lest blood pressure fall. If needed to prevent bucking, a small additional amount of Pentothalcurare may be used up to the maximum previously stated. Once the patient is asleep, the second intravenous infusion is started, essentially the same as the first.

The patient is then slowly and carefully moved to the cooling blanket. If it is anticipated that a markedly lower temperature will be needed quickly, the blanket is connected so that the patient lies on one blanket, a second blanket is on top of him, and a third short, correctly modified blanket is enclosing his head. Usually a delay of 20 to 40 minutes is maximum. At this time the patient's body temperature usually is in the neighborhood of 93 degrees F. The more quickly it becomes necessary to occlude a major vessel, the more rapidly the temperature is lowered in anticipation.

Ether is the basic anesthetic agent. This is added gradually in minimum quantities. It must be emphasized that these quantities are truly minimal. They approach the concentrations necessary for analgesia in our opinion. Frequently the patient reacts to the skin clamps or to the initial incision. Usually the relaxation is rather marked. These patients are maintained by the addition of small amounts of ether as required. During most of the procedure, however, the ether vaporizer is not in use. We wish to emphasize that during the entire procedure, the ether vaporizer rarely is turned on to more than one-third of its capacity, and this for only short periods of time. Curare, once the induction occurs, rarely is needed but when it is needed, small doses of dimethyl d-tubocuraine, rarely more than 1 mg., are given at any one period of time.

The thermostat on the blanket temperature-maintaining unit is set so that the temperature of the circulating fluid in the blanket is approximately 34 degrees F. We have seen no injury to tissues in this way and the fall in temperature has been adequate. The body temperature is continuously taken. Probably the ideal method is by the use of the electrical thermocouple electrode, placed in the rectum. In maintaining the temperature, it must be kept in mind that the addition of cold fluids that have been attached to the I.V. or the blood are extremely valuable in obtaining hypothermia. Speeding up the rate of infusion will frequently markedly increase the rate of fall. Also a slight increase in the amount of Phenergan or Thorazine will aid in the attainment of an acceleration in the fall of body temperature.

Unless rapid bleeding occurs, blood pressure and pulse are relatively stable. However, respiration seems to be increased slightly. But, the amplitude probably would be slightly diminished. When this occurs, respiration is either supplemented or controlled to prevent this from existing for any period of time. We have noted in a number of cases that respiration has a slight gasping quality not unlike a tug. When this occurs, respiration should be increased to a greater degree so that the maximum amount of carbon dioxide is being eliminated. But care must be exercised that the vaporizer is not in the circuit at the time lest the patient be pushed into much deeper planes of anesthesia. In fact, it may be his unrecognized depth of anesthesia that is primarily responsible for the tug.

The skin is always in good color and dry, the veins are not constricted, and the skin temperature has a cool, almost cold frightening feeling in many cases. It is important that these last physiologic signs be noted since if shock should occur, and there is a change the skin quickly shows pallor, a tendency to air hunger develops, the veins constrict, and the insidious but definite signs of shock are seen.

If clamping is necessary above the renals or in the chest, the temperature that we consider

ideal for this patient at this time is in the vicinity of 85 degrees F. This is attained during the course of the isolation of the major vessels. The blanket, the intravenous fluids, the blood, are important factors in this attainment. However, care is necessary since it is easy to lower temperature beyond that which is desired. A fall of as much as 4 degrees F. lower than is desired may occur if the temperature in the blanket is not reversed quickly as the desired temperature is approached.

If clamping of the vessel raises the blood pressure above the level desired, a small increase in the concentration of ether may be all that is necessary. Or, if the blood pressure does not fall adequately with this maneuver, intravenous infusion of Arfonad® must be utilized. This usually is needed when there is degenerative disease in the major vessels, or when the thoracic aorta is occluded. Otherwise, the blood pressure will rise to such a height, a cerebral vascular accident may occur. The blood pressure, however, usually returns to its normal level within five to 10 minutes after Arfonad is discontinued. However, it must be emphasized that this may not be used if blood volume has not been adequately maintained.

Blood must be replaced as it is lost during the entire procedure. Pumps may be used to increase the rate of administration if and when necessary. From time to time the team should communicate with each other as to their estimation of the blood loss and the adequacy of the replacement as well as the progress of the surgery and anesthesia so that timing of all procedures may be carried out fully. Vasopressors have rarely if ever been used in this series of cases. There is no objection to vasopressors as a crutch but we feel that fluids should be managed in a more physiologic manner.

The blanket is reversed as soon as the temperature is within two to three degrees of the level desired.

## POSTOPERATIVE MANAGEMENT

The patient can be left on the table and the blanket used to raise the temperature or he can be returned to his room where an electric blanket or hot water bottle carefully used may aid in returning the temperature to normal. However, it must be emphasized that shivering at any time is a sign that the well being of the patient is endangered. Sometimes the addition of small amounts of barbiturates, Phenergan, or Thorazine may aid in controlling shivering. When the operative procedure is completed, most patients will respond slightly to a painful stimulus or to the spoken voice. However, all appear sleepy and somewhat depressed psychologically. But the respiration, pulse, blood pressure, circulation, all appear adequate.

The intravenous infusions are continued. If necessary, small amounts of a glucose infusion or invert sugar may be used to maintain them. These are not removed until maintenance of blood pressure will not require their utilization. Oxygen is administered by catheter, mask or tent. Aerosol therapy with Alevaire or with Alevaire and antibiotics, bronchodilators, or vasoconstrictor drugs may be used where indicated, especially on patients who have endobronchial secretions. An indwelling gastric suction tube is put in place before the patient is moved from the table. Narcotics are kept to an absolute minimum. In many patients one to two doses of Demerol (10 to 15 mg. per dose) is all that has been required. Pain rarely is a real problem.

It must be emphasized that these patients must be watched carefully and continuously for adequacy of circulation, especially in the limbs that show degenerative changes. The stir-up regimen must be started as soon as the patient returns to the ward.

*MORTALITY IN HOMOLOGOUS GRAFTS*

| | *Living* | *Dead* |
|---|---|---|
| Aneurysm | 21 | 5 |
| Abdominal | 20 | 4* |
| Thoracic | 1 | 1 |
| Leriche | 13 | 2 |
| Coarctation | 12 | 0 |
| | 46 | 7 |

*2 cases ruptured before surgery.

At this time we have successfully completed 53 homologous grafts. Of these, 46 patients are now living and 7 have died. In the aneurysm group of 21 patients, 5 have died. Two were patients who were bleeding at the time of the operative procedure, and in spite of heroic therapy, they were beyond our ability to resuscitate. One patient died on the fifth day of a cardio-

vascular accident; one as a result of thrombosis of a major vessel distal to the graft; one patient died on the 14th postoperative day as a result of rupture of a degenerative portion of a blood vessel, again proximal to the graft.

In the Leriche's syndrome, 15 cases were attempted and accomplished. Thirteen are now living and well. One patient died because of a retrograde thrombosis and the second of a cause undetermined at autopsy. Twelve coarctations had homologous grafts. The mortality in this group is zero. Where degenerative disease is most marked, we find the greatest mortality. We feel that in none of these cases were the anesthesia techniques directly responsible for the demise of the patient.

**DISCUSSION**

These patients represent a poor risk group in that they all have vascular disease and are geriatric, either chronologically or physiologically. The techniques, therefore, must be carefully controlled so that all vital functions are adequate not only during the procedure but in the postoperative phase. This technique permits major surgery with few signs of stress. These patients look good and require little if any resuscitation. All vital signs are good except for psychic depression. They rarely are restless and need little sedation. The skin, blood vessels and pulse all indicate that the patient's condition is good. There have been no accidents due to this technique. There were no immediate postoperative deaths due to coronary or other cardiovascular accidents. Obstructive vascular phenomena that developed were due to the vessels that could not be adequately opened during surgery. No accidents have occurred in which we believe the anesthetic technique to be implicated. The surgeons have been able to block off the circulation for as much as half of the body for periods as long as an hour and 20 minutes. Renal function as a result of this obstruction has shown little if any damage. Even adrenal function has given no problems.

It is the opinion of all the members of the team that this technique protects against shock and stress. We have not had to cancel a single case once induction was started. This method makes the work of the surgeon much easier. The anesthesia, however, requires extreme skill and is not a technique for technicians, the novice, nor the partially trained individual. The hazards are marked due to the disease and the complexity of the technique. The total result is of marked benefit to the entire surgical team as well as the patient.

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## The pathology of Meniere's disease

For the first time in the history of otology, I have studied histologically the membranous labyrinth removed in vivo during the performance of the labyrinthectomy for the arrest of vertigo in Meniere's disease. In 28 consecutive cases, I found the inner walls of the membranous endolymphatic labyrinth studded with ruptured and unruptured epithelial vesicles. As a result of this study, I advanced the theory that Meniere's disease is not due to hypersecretion or poor resorption of endolymph but rather to a herpetic neuritis of the vestibular branch of the eighth nerve. The paroxysmal attacks of vertigo are due to periodic rupture of vesicles, and contamination of endolymph by toxic fluid. Deafness is secondary to the action of the contaminated endolymph on the hair cells of the organ of Corti. Since the endolymphatic labyrinth is of ectodermal origin embryologically, I investigated and compared the pathology of vesicles in herpes zoster and found the cellular pathologic changes the same as in Meniere's, thus strengthening further my theory of Meniere's disease. *Julius Lempert, M.D. Modern Otology. Postgrad. Med. Dec.* 1955.

# Observations On The Aging Process

**Louis E. Graubard, M.D., Galesburg**

IT is strange that the one thing that every person looks forward to is the one thing for which no preparation is made. Primitive man, like the child, apparently gives no thought to the process of growing old. He lives for the passing day. It should be helpful to know more about age and senescence. It should help the aging man to understand his own very difficult undertaking. The famous bacteriologist and Nobel Prize laureate, Metchnikoff, once said "Science knows very little about old age and death". In the aging organism occur many anatomical, physiological and physiochemical alterations. Yet this area of research still is relatively undeveloped. I remember working in 1940 under Professor Muller-Deham of Vienna who first coined the term "Geriatrics".

Progress in medicine, discovery and development of new drugs, better personal hygiene and more adequate dieting remove more and more obstacles to longer life. Yet we really do not know why people grow old. Why do some retain their youth long while others age early? Many theories have been advanced. One theory postulates the existence of "A Primary Aging Factor," undiscovered as yet. This aging factor automatically limits human life to about 100 years. Another theory maintains that there is no such factor and that senility is due to the amount of stress endured during life.

Some of the aging processes are physiological. After the foetus emerges from the womb and begins to grow, a relatively short period of maturity follows. Then the vital curve begins to sink—the reverse process of involution. It is difficult to indicate precise limits for the various periods of life. There may be early maturing and precocious development or on the other hand, late aging. Henry Cazalis, a French physician, said "a man is as old as his arteries".

The famous pathologist, Ashoff, has shown that for the blood vessels (mainly the arteries) the prime of life is of very brief duration; all growth ceases at about the thirty-third year. Ten years later the first alterations characteristic of aging begin to appear. For our climate and culture it may be assumed that the age between twenty-five and forty-five is the prime of life; in man, the age to reach the desired goals in life; in women, the period of fertility.

Virchow demonstrated that the tissues of the body do not all come into existence at the same time and they do not all die at the same time. Youthful tissues occur in extreme old age and senescence tissues in the foetus. Okenian bodies fulfill their task before the child leaves the mother's body, and then perish. The thymus gland begins to atrophy in puberty. Again the fate of the milk teeth is an example of early aging. Not unjustly, life has been described as a gradual dying.

Senescence begins when the phenomena of atrophy predominate. Atrophy of higher and specific elements is followed by hypertrophy of less specialized cells. In the brain, the highly developed nerve cells are replaced by supporting tissue which is of much lower differentiation. In the liver, glandular cells are ousted by supporting tissue; in the kidney, the channels which are necessary to rid the body of waste are occluded by supporting tissue.

The skin becomes dry. The most exposed parts (hands and face) begin to wither. Fluid is lost in the tissues which accounts for loss of weight. The whitening and falling out of head hair, the increased appearance of facial hair in females, and the change of pitch in voice brings about such similarity of sexes that at times we have difficulty distinguishing old men from old women.

When does old age begin? According to Hippocrates—in the fifty-sixth year of life. Dante, the famous author of "The Divine Comedy", said between forty-five and seventy, and described anything beyond as senility. Laccanssagne, a French authority, offered the following classifications:

60—70 — springtime of old age
70—75 — green old age
75—80 — true old age (LaVrais Vieillesse)

*From the Galesburg State Research Hospital, Galesburg, Illinois, March* 1, 1956

80—90 — extreme old age

There is no firm rule. We have seen, and still see some who, according to normal standards ought to be in wheel chairs, slobbering, trembling, mumbling, and edentulous, effectively ruling the destinies of countries. Others produce masterpieces—Sophocles wrote "Oedipus", still the model of the classical tragedy, when he was ninety. Titian painted masterpieces at eighty-five. Oliver Wendell Holmes was eighty-five when he wrote his famous essay "Over the Tea Cups". Verdi composed "Othello" when he was eighty. And in our times Bernard Baruch, Winston Churchill and Helen Keller are dramatic examples of real achievement in old age.

The desire to postpone aging is as old as man. Magic potions and fountains of youth are still sought. In Goethe's immortal story, Faust, gives his soul to the devil for eternal youth; but this does not work out too well, and in the end he begs Mephisto to annul the pact. There is an unfair aspect to aging in males as against females. If an old man does not "act his age" he evokes comments like "youthful", "chipper" and "charming" while the aged female who tries to appear younger meets with scorn and ridicule.

Many maladies make their appearance in old age as part of the process of deterioration. Other disorders that may appear in earlier phases of life assume a different and more dangerous character in later years. Pneumonia is a typical example. Pulmonary infections of old age are marked by slow and imperfect clearing-up of congestion. However, there are no dramatic crises, especially in diseases of the digestive system, and it is important to watch for mild complaints which can accompany a ruptured appendix, an inflamation of the gall bladder, or even the perforation of a gastric ulcer.

Old people show exaggerated interest in themselves, craving for attention and frequent medical examinations for slight ailments. They are unwilling to live alone and give up previously highly treasured independence. Boredom—"l'ennui mortel"—can be dangerous in old age.

It is interesting to compare how respect is paid to old age in different cultures. Western chivalry takes delicate consideration of a woman's age. The Chinese culture places emphasis on respect of the aged. After introductions it is very polite to ask "and what is your honorable age?".

Old age is not merely a decline of virility; it also is a season of peace and contentment unknown in earlier life. It is astonishing to what an extent human faculties are preserved despite the encroachments of old age, as long as the central organs, particularly the heart and the brain, are not worn out or diseased. Wisdom, experience, mellowness and peace of mind are the achievements of old age. It is regrettable when this has been achieved that life's rewards are curtailed and limited by society. George Bernard Shaw considered old age desirable though not enviable, and he felt that youth was too precious to waste on the young.

Of the utmost interest in a mental hospital are the characteristic changes in behavior. From ten to fifteen percent of admissions to mental hospitals are cases of simple dementia. The disorder begins with narrowing of the range of interests, forgetfulness, dulling of emotional reactions, and symptoms like those that occur in physiological senescence. But in senile dementia the changes occur more rapidly and intensely. Loss of memory, falsification of memory, faulty attention, difficulty in concentration and slowing of perception become marked. Gaps of memory are often filled with silly confabulations. In conversation, thread of discourse is often lost and attention either can be deflected or the senile adheres tenaciously to certain fixed ideas. Severe disturbances of orientation in all spheres are common. Patients may become lost in streets, identify and mistake strangers as relatives, and can be victimized easily by swindlers.

Pedantry, egotism, pathological suspiciousness, avarice can be characteristics. Absence of mental clarity, episodes of clouding of consciousness, and so-called twilight states are common. Infantile behavior, the so-called "second childhood", is exemplified by King Lear:

> "He did not know where he had lodged the night before
> Nor whence the garments that he wore had come
> The foolish, proud old man, fourscore and upward
> Had become a babe again."

Irritability is frequent as well as disturbances in ethical domains, sexual misdemeanors, hallu-

cinations (especially auditory), and delusions (hypochondriasis and persecutory). Incontinence and involuntary bowel movements may occur daily. Abnormal wills, selling of property at ridiculous amounts, and silly marriage contracts may be seen.

Though the course of senile dementia is progressive, physical life may continue for many years, death ultimately coming from intercurrent diseases. Great care must be exercised to prevent seniles from certain injuries such as hip fractures from slips in bath tubs or falls on rugs. Fear of accidents can become so marked that it cripples. Some old people get so afraid of falling that they go to extremes to avoid this. They simply refuse to walk—and cannot—paralyzed by fear. Inactivity leads to atrophy and immobility. It is a happy day with some old people if they finally get into a wheelchair for good.

Primitive people hardly knew what to do with their old people. They were a superfluous burden. The Fiji Islanders preferred to kill themselves, a custom connected with their conception of the future world. They believed that one enters Elysium (Paradise) in the physical and mental state which obtains at the moment of death. This was also the case with most of our Indian tribes who felt it was important to enter the "eternal hunting grounds" and therefore displayed unlimited courage.

Among the Indians of the Gran Chaco an old man expects his son, as a service of love, to strike him dead as soon as he proves no longer capable of coping with the most strenuous tasks required in that rugged environment. Among the Herulians, an ancient German tribe, too, it was the custom to kill the aged and the sick at their own request. The mentally intact, on the other hand, were highly respected and their council held in high esteem. The Council of the Gerontes in Sparta (from which our term gerontology is derived) had tremendous power and could overrule, in certain instances, decisions of the majority. "Only in Sparta is it good to grow old."

Most of us have similar personal experiences when we suddenly face the problem of being with older people. A stroke with its serious consequences, diabetes, amputation of a limb, a crippling arthritis, throws our dearest relatives, who before vehementaly objected to any type of dependency, into our laps. Naturally we are not happy about this, nor is the job a very pleasant one. To nurse is to sacrifice. Our patience is taxed to the limits and we may be embarrassed no end by silly misbehavior, impulsive acting-out, poor judgment, or exhibitionism suddenly manifested by grandfather. This is not only a special problem but economic too. This often becomes a strong defensive rationalization to cover guilt feeling. "Besides, it is not good for the children to see this, so off to a "home" goes grandfather.

In a recent survey Dr. Otto L. Bettag, Director of the Illinois Department of Public Welfare, pointed out that many old people are placed in state mental hospitals mainly because this is a relatively inexpensive and socially confortable arrangement. Obviously this contributes to overcrowding and deprives the really sick of adequate care.

According to Venus, ancient goddess of beauty, "even the gods hate old age", and Lord Byron said, "There is only one misfortune in life that cannot be repaired, and that is the misfortune of no longer being twenty-five years old." Old and senile are very often synonymous and so we can understand Pope Pius XI, when he prayed, "Grant me the privilege to age gracefully." If the disagreeable characteristics are absent we feel like Pope Leo XII. When he was entering the ninetieth year, and was congratulated by a lady who said he would surely live to see his hundredth birthday, he exclaimed, "Madam, why set a limit to the Divine kindness?"

There is no clear basis for crediting long life to a certain mode of life. Moderation in eating and abstinence from tobacco and alcohol have many supporters. Yet, it is common knowledge that many old people enjoy indulging in rich food, fine beverages and heavy cigars.

I remember a trip through the Austrian Alps when I stopped at a mountain inn. I was waited on by a giant with white hair, flashing teeth and aquiline features. I asked his age. He said, "Ninety-one, sir." To my question how he achieved his excellent health, he replied that he had never used tobacco, alcohol or indulged in any other excesses. A terrific noise interrupted our conversation and the innkeeper went out to find the cause of the racket. On returning he remarked quite casually: "That's just my older brother coming home drunk!"

# Amebiasis and Amebic Dysentery

Manuel G. Spiesman, M.D. and Louis Malow, M.D., Chicago

CHRONIC intestinal amebiasis is a condition which is much more prevalent than realized by the average general practitioner. It should not be confused with amebic dysentery which is comparatively uncommon in the temperate zone. The term amebiasis is so frequently associated with dysentery in the minds of many physicians, that when a patient does not have diarrhea and bloody stools, the diagnosis is not suspected.

Amebiasis means that condition in which Endameba histolytica cysts or trophozoites are found in the stools of patients who have many apparently unrelated symptoms. A goodly number of patients in whom we have made this diagnosis have been treated for spastic colon, irritable bowel, chronic appendicitis (with and without surgery), pruritus ani, or psychoneurosis.

In acute amebic dysentery the patients usually are quite ill and have numerous liquid stools (up to 20-30 daily) with mucus and blood. Fever, malaise, abdominal cramps, and tachycardia usually are present: all of the usual signs of toxicity plus diarrhea.

Although amebic infections were formerly thought to be prevalent only in Central American, South American, Asian, and African communities, recent surveys have revealed a fairly high rate in the United States. The following are a few of the statistics given in the literature.

| | *Per Cent* |
|---|---|
| Reports from gastroenterologists and parasitologists in Memphis | 17 |
| Veterans with domestic service | 10.1 |
| Soldiers in China-Burma-India theatre | 28.3 |
| Orphanage children in Canada | 37-50 |

Pruritus ani in our experience is caused by amebiasis in 50 per cent of our cases.

Small cyst strains of Endameba histolytica not commonly diagnosed in laboratories are pathogenic, but are believed to be less pathogenic than large cyst strains. It has been found in laboratory animals that the presence of colon bacteria such as Escherichia coli, or aerobacter aerogenes, implanted in the cecum of germ free guinea pigs, previously inoculated with ameba, produces typical ulcerative amebiasis. This may be important because the successful treatment of intractable cases of amebiasis usually requires antibiotic therapy.

Felsenfield and Comess believe amebic parasites are reduced under a high protein, low carbohydrate diet. Whether this influence is exerted on the amebas or the bacteria is as yet unknown. It is believed by most investigators that the amebic cysts are transmitted through infected water, fresh vegetables and fruits, and by food-handling carriers.

Although the initial lesions in an Endameba histolytica infection are found in the colon, extraintestinal manifestations occasionally are found in the liver, lungs, and pleura. Rarely, cerebral and splenic abscesses are seen. Apparently asymptomatic cases may or may not present discrete minute ulcers with normal mucous membrane between. The favorite sites of the infection are in the ileocecal, ascending, sigmoidal, rectal, and perianal regions. Most frequently patients with chronic amebiasis present only the cyst in the stool without any visible mucosal findings.

In acute amebic dysentery the lesions are more extensive, presenting button-hole ulcerations ranging in size from just visible to a little less than ½″ in diameter with normal mucous membrane in between. Submucous sinuses may connect the discrete ulcers with eventual coalescence and formation of larger irregular shaped ulcers. Bloody mucus is seen with but little pus, unless secondary invaders complicate the infection.

An indurated tumor (ameboma), occasionally is found in any part of the colon and rectum resembling carcinoma or a chronic inflammatory mass. This is important to keep in mind when a carcinomatous lesion presents itself on proctosigmoidoscopic examination or X-ray. Biopsy and stool studies help to establish the diagnosis.

The most common extraintestinal manifesta-

tion of amebiasis is pruritus ani. A mild amount of recurring and intractable perianal dermatitis with slight erosions has been noted in at least 50 per cent of our cases of amebiasis.

The next most common extraintestinal manifestation is hepatitis which may be present at any time during the course of infection and is the result of amebic infection in the rectum and colon. Abscesses are usually single and occur more commonly in the right lobe of the liver. The abscess contains chocolate-brown material consisting of liver tissue and blood. If secondary bacterial infection occurs, a purulent exudate is found on aspiration. This is important to determine because antibiotic therapy as well as amebicides are then indicated.

Pulmonary abscess may develop from direct extension from a liver abscess or by embolism from the bowel, the latter being rare. If the hepatic abscess ruptures into the pleura without extension into the lung, it may produce pleural effusion. Rare manifestations of amebiasis are cerebral and splenic abscesses. Infection of the skin occasionally occurs around a draining liver abscess.

D'Antoni, who has contributed a great deal to the subject of amebiasis, offers the following symptomatic classification. (Pruritus ani which we have found frequently caused by chronic amebiasis has been added to A of section 2 of the following):

1. Asymptomatic amebiasis:
   Patient not cognizant of symptoms with lesions not confined to specific areas.
2. Symptomatic amebiasis:
   A. Asyndromic (forme frustes)
   Mild toxemia and vague gastrointestinal irritation, with lesions usually not confined to specific areas. Pruritus ani may be present.
   B. Syndromic:
   Symptoms simulating chronic appendicitis, peptic ulcer, chronic cholecystitis, with lesions usually confined to cecal area. Pruritus ani is commonly present.
   C. Dysentery (acute or chronic):
   Symptoms of dysentery, with lesions throughout colon, especially rectum and sigmoid.
   D. Hepatitis and liver abscess:
   Fever, pain, and tenderness in liver area, with lesions in liver tissue.
   E. Involvement of other organs:
   Abscess of lung, brain, kidney or amebiasis cutis.

Fatigue occurs most commonly. Constipation, alternating with diarrhea, unexplainable vague pains in the abdomen (bowel consciousness), gaseous eructations after eating, unstable pulse, tachycardia, nervousness, and irritability may be present. Headaches are recurrent and may last for several days. Low grade afternoon fever of 100 degrees F. occurs occasionally. True diarrhea occurs in no more than 5 per cent of the cases.

Chronic infection and invasion of the wall by Endameba histolytica occasionally results in the formation of a granulomatous mass which may be detected on sigmoidoscopic examination or barium X-ray examination or on abdominal palpation. These lesions closely resemble carcinoma and have been resected for such. If the lesion is in the rectum or sigmoid, biopsy and stool analysis will establish the diagnosis. When the lesion is beyond the reach of the sigmoidoscope, the diagnosis becomes more difficult, but if the stool reveals positive finding, the patient should be placed on a rigid course of amebicidal therapy before surgery is seriously contemplated. One must keep in mind, however, that carcinoma may be present along with amebic trophozoites or cysts in the stool.

The early stage of amebic hepatitis may be so mild and symptoms so vague, it is entirely overlooked. Or there may be hepatic enlargement and tenderness associated with pain on deep pressure over the liver. Liver function tests usually are normal.

With abscess formation there is a restricted mobility and fixation of the right leaf of the diaphragm, obliteration of the cardiophrenic angle, slight icterus, elevation of the white count, and a rise in temperature. Liver function tests usually are normal.

## DIAGNOSIS

The absolute and most important finding in amebiasis is the visualization under the microscope of the motile or cyst forms of Endameba histolytica. Proctoscopic and sigmoidoscopic examinations help corroborate the diagnosis. This

is usually accomplished by the following laboratory tests:

1. Fresh stool — unstained
2. Fresh stool — stained with D'Antonis iodine stain
3. Fixed smear — using Faust's hematoxylin stain
4. Zinc sulfate centrifugal flotation test
5. Compliment fixation test (still in experimental stage)

These tests are added in this chapter, so that the proctologist, surgeon, and general practitioner will be familiar with the procedures and will be in a position to request same from the laboratory.

It must be kept in mind that a negative result is not proof that amebiasis does not exist. Tests have to be repeated. Occasionally suspected cases are placed on amebicidal treatment despite negative findings.

Routine Test Procedures:

1. 1 to 3 normally passed stools.
2. A morning stool following a saline purgative the night before.
3. Swabbing ulcers from intestinal mucosa and studying smear.
4. Aspirate with long glass tube to which is attached a rubber suction bulb, from suspected areas of the mucosa through a sigmoidoscope.

In cecal infections cysts usually are found while motile trophozoites suggest rectosigmoidal involvement. Compliment fixation tests, although 90 per cent efficient, still are in the experimental stage and usually not available because of the difficulty in obtaining, preparing, and standardizing a suitable antigen. Clusters of fatty acid crystals in the stool recently have been found in cases of chronic amebiasis, which do not reveal amebic cysts and trophozoites.

In chronic amebiasis there usually are no mucosal findings on sigmoidoscopic examination. Occasionally, typical yellow elevated nodules or pinhead-size discrete ulcers are seen with apparently healthy noninflamed mucosa between. In amebic dysentery the lesions appear as minute circular pits or depressions. The margins of the typical amebic ulcer are undermined, and the floor is covered by a grayish-white material which contains amebas. The ulcers range from 2 to 3 cm. in diameter. Submucous sinuses may connect the discrete ulcers, with eventual coalescence and formation of larger irregular shaped ulcers. Bloody mucus is seen but no pus, unless secondary invaders complicate the infection. As the word "histolytica" implies, there is a "lyses" of tissue, the Endameba histolytica not being a pus producing organism.

Cysts usually suggest infection in the cecum while motile trophozoites are mostly found in patients where the lesion is in the rectum and sigmoid. In young people, where the initial X-ray of the chest reveals complete obliteration of the lung field on the right side, these cases are mistaken for empyema or a tuberculous pleural effusion. The demonstration of chocolate-brown visual fluid, however, plus stool findings establish the diagnosis of amebiasis with hepatic involvement.

In older people, ruptured abscesses into the pleura have been mistaken for malignancy of the lung and pleura. The visual chocolate-brown fluid obtained on thoracenthesis, plus the absence of tumor cells on smear of the fluid, and the evidence of an infectious process as shown by a high white blood cell count and increased temperature, establish the diagnosis of amebiasis.

Some cases of liver abscess have been mistaken for pneumonia because the patient presents a picture of sudden acute chest pain with X-ray findings in the right lower lung, simulating primary pneumonitis. Lateral views plus other findings establish the diagnosis. It has been suggested, that it is wise to consider the possibility of amebiasis in any chest lesion in which the area of the right diaphragm is obscured.

If there is a reduction in excursion, restricted mobility, or fixation of the right leaf of the diaphragm, obliteration of the cardiophrenic angle, slight icterus, elevation of the white blood count and fever with normal liver function tests, amebic abscess usually is the diagnosis.

Whenever there are many remedies offered for the treatment of a disease there is no specific cure. This is true for amebiasis. We have excellent remedies and we can control the disease but we sometimes wonder whether we ever completely eradicate the parasite.

However, by getting the disease under control and the patients symptom-free, and by prescribing Diodoquin® for a week once a month thereafter, we can keep the disease under control and

relieve symptoms in about nine out of 10 cases. The following are the combinations of treatment and laboratory examination used in acute and chronic amebiasis.

The drugs are divided in the following groups and are presented in each group in the order of their found value and tendency towards systemic reactions. Also, to aid the physician in changing courses and medications when reactions occur, dosage is given for each.

### *IODOQUINOLINES*

*Diodoquin* — 6 to 10 tabs. (.10 gr.) daily for 16 to 20 days.

*Vioform®* — 1.5 to 3.0 Gm. daily for 7 to 10 days. (May produce undesirable G. I. symptoms).

*Chiniophon* — (least effective) — Dose 0.25 4 times daily.

### *ARSENICALS*

Do not use these drugs when liver damage or intolerance to arsenicals is known. Do not use these drugs for more than 10 days at a time.

*Carbarsone®* — 0.25 Gm. — 1. caps. b.iid. for 10 days only.

*Milibis®* — supposed to be less toxic. 0.5 Gm. 3 times daily, 7 days. (Not as good in children as in adults).

*Fumagillin®* — Dose 20 mgm. 3 times daily for 10 days.

### *AMINOQUINOLINES*

*Chloroquine* — (Aralen)®, is absorbed rapidly and has a low toxicity. Frequently used instead of emetine. Good in hepatic amebiasis, not in the colon variety. Diodoquin can be given concurrently or after chloroquine. Dose — 1 Gm. daily for 2 days, then 0.5 Gm. for 19 days.

### *ANTIBIOTICS*

These eradicate intestinal bacteria, the presence of which seems to be necessary for growth and multiplication of amebas.

*Penicillin* — Dose 600,000 U. daily.

*Sulfasuxidine®* — Can be used instead of or alternately with penicillin, followed by Diodoquin Gm. 6 to 10 daily.

*Achromycin®* — 2 Gm. daily for 10 days.

*Terramycin* — May produce undesirable side effects.

*Aureomycin* — Is absorbed and has a systemic effect. Mycin drugs should not be used when there is a history of nausea, vomiting, diarrhea, abdominal pain, or pruritis ani following the previous use of such drugs. Dose — Gm. 1 daily for 10 days.

### *EXTRAINTESTINAL AMEBACIDES*

(Liver, lung, and pleura remedies)

*Emetine* — Highly toxic and should be used with great caution. Dose — 1 gr. a day subcutaneously for no longer than 7 days.

*E. B. I.* — (Emetine-Bismouth-Iodide) compound — not for ambulatory cases, because of toxicity. Considered good by the English. Used in intractable cases. Dose 65 mg. tablets a.m. & p.m. for 10 days.

*Milibis with Aralen* — Therapeutic test dose — tabs. 2, t.i.d. for 7 days.

For a quick start and for rapid results in troublesome, difficult cases, an injection of 1 gr. emetine hydrochloride and 1 capsule of Carbarsone 6 times on the same day are given. This combination also may be used as a therapeutic test. If the patient receives prompt relief, amebiasis should be diagnosed, even though the stools are negative. The following are the five types or stages of amebiasis and treatment for each, including prophylactic treatment:

### *SUGGESTED COURSES OF TREATMENT*

*1st Course*:

1. Prophylactic Treatment
   1 Diodoquin tab. gr. X, t.i.d.
2. Chronic Amebiasis (colon type)
   Diodoquin gr. X tabs. — 4 to 6 tabs. daily for 10 days.
   Carbarsone 0.25 Caps. — 1 b.i.d. for 10 days only (very toxic).
   Diodoquin — same as above for 10 days.
   Carbarsone — same as above for 10 days.
   Bland high protein diet.
   Repeat stool analysis 1 week after cessation of medication.

*2nd Course*:

If the stool still shows cysts, prescribe Achromycin 2 Gm. daily for 10 days. Aralen-Milibis Tabs. — w Tabs. t.i.d. for 7 days. The above drugs are given concurrently. Examine stool after course of therapy.

*3rd Course*:

If stool is still positive, prescribe and administer Combiotic (Penicillin and Strep-

tomycin) 1 cc. daily for 6 days. Aralen — 1 Tab. b.i.d. for 14 to 21 days.

*ALTERNATE COURSES*:

Combiotic for 6 days, followed by Achromycin 2 Gm. in divided doses. Aralen and Milibis concurrent with above, 1 tab. q.i.d. for 16 days.

*1st Course*:

Emetine — 1 gr. daily for 7 days. Diodoquin — gr. X, 2 Tabs. 3 times daily, for 10 days. Bland high protein diet. Check rectal-sigmoidal mucosa with sigmoidoscope and repeat stool. If positive findings, wait a week and give the following:

*2nd Course*:

Aralen-Milibis Tabs. — 2 t.i.d. for 7 days. Achromycin — 2 Gms. daily for 10 days.

*HEPATITIS*

Chloroquine (drug of choice) 1 Gm. daily for 2 days and 0.5 Gm. daily for 19 days. If toxic symptoms develop, discontinue medication for 24 to 48 hours. Thiamine — 100 mg. and Rubramin® 30 mg. daily hypodermically daily for 30 days. Low fat, high protein, high carbohydrate diet. Stool — check six weeks later.

*HEPATIC ABSCESS*

Some abscesses will heal with drugs alone; others require needle aspiration or surgical drainage and drugs. Treatment should be tried in the above order given.

**SUMMARY**

Chronic intestinal amebiasis is the most common form of this disease and should be suspected when patients complain of pruritus ani or vague abdominal symptoms. (The ulcerative dysentery type occurs in only 5 per cent of the cases.) A negative stool does not rule out amebiasis. Several stools should be examined, some after a saline laxative as the ameba is difficult to find. Amebic hepatitis should be suspected where an enlarged and/or tender liver is found. Liver abscess, which is not very common, should be kept in mind and suspected when X-ray examination reveals abnormal contour of the right diaphragm. X-ray examination may also locate an ameboma. The sigmoidoscope is valuable in visualizing discrete amebic ulcer with apparently healthy mucous membrane between. It is also helpful in obtaining biopsies for differential diagnoses. A viscid pleural fluid with or without blood should be considered suspicious of amebic ruptured abscess.

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## We need religion

Overprivileged America, often willing to be neglectful of the spiritual, tried to convince itself that material plenty would satisfy all needs. Comparative wealth has become the lot of most, yet the nation stands empty handed wondering why the hunger. Ambitious America sought to supply education for all and high education for the many believing, in its infantilism, that education was the ointment of soul fulfillment. The land abounds with those bearing the label of education but the great emptiness remains. Bountiful America, through unwanted but still bloody wars, sought new worlds of idealistic purport, chiefly for others. The nation still is poking around in the ashes of disillusionment. Generous America lavished its money on less favored countries, hoping against hope that sparks of goodness would lead to flames of spiritual amplification the world over. Instead, the results have been scarred by snickering, greed, and enlarged envy. America as a nation stands more than empty handed as a spiritual entity; it stands stark naked. It is no miracle that a resurgence in religion is grasping the people. This is the last resort when it should have been the first. Even yet, Christianity may be tried out in its gracious offerings. *Resurgence in Religion. Indust. Med. Feb.* 1956.

# Illinois Physician-Botanists

**Egbert W. Fell, M.D., Rockford**

THE medical profession has contributed many stars to the botanical firmament. Formerly the study of materia medica and the search for medicinal herbs developed an interest in plants, but now, since materia medica is left so entirely to the pharmacist, that incentive does not operate with doctors. The slower transportation of earlier days in more rural surroundings was conducive to contemplation and to observation of what grew on the roadside before the invention of 2,4-D. Perhaps the basic reason for doctors being interested in plants is that they were nature lovers before they became medical students.

Doctor-botanists have, with a few notable exceptions, been field workers as contrasted with the desk-type professional who spends his time in the classroom or with the dried plants in the herbarium. He has been a man of action, studying plants in their habitats, writing notes about them and making collections of his discoveries. This he did because of his love of living things. There was no material gain for him and the pursuit of the hobby often interfered with his professional work. Most of these men lived long; a famous doctor-botanist wrote in 1865, ". . . . although 72 years old I am still able to follow my profession and have traveled about 20 miles this day through very deep mud and slush." His traveling was not by automobile. He found time to write an elaborate two volume book about the genus Carex.

In reading of the lives of these men it is noticed that, while they differed as to individual peculiarities, all had in common, beside the love of growing things, "the enjoyment of large practices and in being greatly beloved by their neighbors," but that they invariably died broke or nearly so. The widow realized what little cash she could by selling the doctor's botany books and plant collection. The same sad state existed with the preacher-botanists and to a less degree with the teacher-botanists but some of the lawyers did better. Kenneth Mackenzie, a successful New York attorney, left money for the publication of his monumental work on the genus Carex.

Carl von Linne (1707-1778), known to us as "Linnaeus", the father of modern botany and the originator of our present system of plant classification, was a medical graduate and practiced for a time in Stockholm. Asa Gray (1810-1888) was given an M.D. degree in 1831. He was the top plant authority of his time in the United States. He was a voluminous writer, his most important work being his Manual of Botany whose first edition was dated 1848 and whose recently revised eighth edition is still the standard in its field. John Torrey (1796-1873), a New York doctor, worked closely with Gray and also wrote independently on many botanical subjects. Many plant names are followed by the initials "T. & G." indicating that the specific name was given the plant by John Torrey and Asa Gray.

The midwest has produced its share of physicians who have become important botanists and the work of the following Illinois men has very materially advanced our knowledge of the flora of our state:

Samuel B. Mead (1799-1880) was the first in point of time. He graduated from a New York medical school in 1824, practiced for a short time in Rushville, Schuyler County and in 1833 moved to Augusta, Hancock County, where he spent the rest of his life. He was the first resident botanist to systematically study Illinois plants and to preserve specimens of his collections. A number of plants were discovered by or were named for him. In 1846 his List of Illinois Plants was published in "Prairie

*Psychiatrist, Rockford Board of Education.*

*Honorary curator of botany, Illinois State Museum, Springfield, and of the Evelyn I. Fernald Memorial Herbarium of Rockford College.*

Farmer". Alice L. Kibbee professor of botany at Carthage College has written entertainingly of his life and work. The doctor, though a good Presbyterian, was somewhat impressed by the "Millerite" prophesy that the world would come to an end on October 22, 1844. A suitable placard that he put on his office door was removed when the day passed without fulfillment of the prophesy and the doctor returned to his usual routine. His plant collection was acquired by Knox College and is now in the University of Illinois herbarium on loan.

Frederick Brendel (1820-1912) graduated from a German medical school in 1843 and came soon after to Illinois settling in Peoria where he practiced medicine until his death. He kept accurate records of the weather before there were government reports. He made extensive plant collections in Peoria and Tazewell counties and wrote many articles, mostly about trees and shrubs, but his chief work was a catalogue of the plants of the area which he called "Flora Peoriana." Its quaint style, accurately recorded observations and wise conclusions are as unique and interesting as the list of plants that it contains.

George Vassey (1822-1893) graduated from Berkshire Medical Institute, Pittsfield, Mass. in 1846 and practiced in Ringwood, McHenry County and in Elgin, Kane County for a time. When his interest shifted more definitely to botany be became curator of the Natural History Museum at Normal and later was appointed curator of the United States National Herbarium. He specialized in grasses in which plant family he was the foremost authority of his time, writing many articles and collecting extensively in Illinois and in the southwest and on the Pacific Coast. Many of his plants are in the Chicago Natural History Museum and in the University of Illinois herbarium.

James T. Stewart (1824-1901) a graduate of the University of Pennsylvania Medical School in 1850 practiced in Peoria. He wrote of the flora of Peoria County, was an ardent plant collector and was closely associated with Dr. Brendel in this work. His daughter, who lives in Peoria, describes the doctor's plant collection as being in about 24 huge books. After his death these went to the Field Museum where the collection was later divided, part being sent to other herbaria.

William Abbott Nason (1841-1918) graduated from Northwestern University Medical School in 1866 and practiced in Algonquin, McHenry County. His large plant collection is now in the University of Illinois herbarium.

Jacob Schneck (1843-1906) graduated from Chicago Medical College in 1871 and practiced in Mt. Carmel, Wabash County. He and Robert Ridgeway, who was botanist as well as ornithologist, were close friends, did field work together and both wrote of the flora of the Wabash valley. The doctor collected extensively and discovered several new species of plants in southern Illinois; but it is said that he always put the demands of his medical practice first.

Stephen Alfred Forbes (1844-1930) was reared in Stephenson County and attended Rush Medical College in 1865 and 1866, then became interested in zoology and later was instrumental in establishing the Illinois Natural History Survey which he directed for many years. Though his main interest was animals he did some botanical work writing about southern Illinois plants and discovering a saxifrage which is named for him.

Will Sayer Moffatt (1847-1941) after graduating from Hahnemann Medical College in Chicago practiced in the city and lived in near-by Wheaton. He was actively interested in botanical society affairs and wrote on various phases of botany, particularly the higher fungi of the Chicago region. His large collection of Illinois and Indiana plants is now in the Chicago Natural History Museum, University of Illinois, University of Wisconsin and various other herbaria.

Charles Frederick Millspaugh (1854-1923) graduated from New York Homeopathic Medical College in 1881. He became professor of botany at West Virginia University and in 1894 was appointed curator of botany at the Field Museum where he remained until his death. One of his many interests was medicinal plants and about these he wrote extensively.

Herman S. Pepoon (1860-1942) was reared in Jo Daviess County, graduated from the College of Physicians and Surgeons, Chicago, in 1883 and practiced for a time in Lewistown, Fulton County. His interest in botany and in young people caused him to leave medical practice for a teaching position in Lake View High School in Chicago. He was intrigued by the peculiar plants

of the unglaciated area in his native county, wrote largely about them and he was responsible for Apple River canyon being set aside as a state park. His major work was his "Flora of the Chicago Region", a manual of 554 pages published in 1927.

Ralph Garfield Mills (1881-1945) graduated from Northwestern University Medical School in 1907 and practiced in Decatur, Macon County. His botanical interest was the study and collecting of allergic plants.

Beside these Illinois physicians a number in neighboring states contributed materially to the knowledge of the plants of our state. Perhaps the most important of these was George Engelmann (1809-1884) who was educated in Germany and practiced in St. Louis. He was an authority on many groups of plants, Cuscuta, Juncus, Euphorbia, Quercus, the conifers and cacti and he was also famous as an explorer, particularly in Colorado, where he discovered and named many new species.

Lewis Caleb Beck (1798-1853) another St. Louis doctor wrote particularly of the plants of Missouri and Illinois and made some important botanical discoveries in our state.

Charles Wilkins Short (1794-1863) was a wealthy physician who practiced in Lexington and Lousiville, Kentucky. He was very active in his profession and also in botany,, writing a catalogue of the plants of Kentucky, articles about Illinois plants and improving herbarium technique.

Charles C. Parry (1823-1890) was born in England and took his medical degree in New York and while there his acquaintance with Torrey and Gray led to an interest in botany. His home was in Davenport, Iowa and he was actively interested in Illinois botanical affairs. He traveled extensively for the U.S. Department of Agriculture and it is said that he discovered hundreds of new plants mostly in the far west. Coulter referred to him as ". . . .our oldest and most distinguished botanical explorer".

Augustin Gattinger (1825-1903) practiced medicine in Nashville, Tenn. in the late 1870s. He took an active interest in botanical society affairs and had a national reputation as a botanist but did not let that interfere with his medical work and he is said to have been a successful doctor.

The recent past has not produced any doctor-botanists of note, a regrettable fact since progress in our knowledge of plants is so largely dependent upon the activity of amateurs—it is they who collected most of the plants that are in herbaria. The basis of botany is the individual plant and progress comes about through contract with these living entities and through a study of fresh and dried specimens. Physicians have, in the past, contributed largely to this progress.

303 Penfield Place.

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## Treatment of tuberculosis

While there is some unanimity that rest should be a fundamental part of the early treatment of active (tuberculosis) cases, there are considerable differences in practice when it comes to the resumption of activities. For some patients, judged to have good resistance and well stabilized disease, the period of idleness may be shortened, and it may be reasonable for them to consider chemotherapy an adequate substitute for a long convalescence. Nevertheless, there should be some restriction of their activities. In chronic advanced cases, temporarily controlled by chemotherapy, patients may be instructed to regulate their activities within the limits of their own sense of fatigue and endurance. These patients frequently cast off tubercle bacilli intermittently, and measures should be taken to safeguard others with whom they may come into contact. *J. Burns Amberson, M.D. Evaluation of Present Day Treatment of Pulmonary Tuberculosis. Ann. Int. Med. Dec.* 1955.

# The Physiology of Aging

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**Conrad L. Pirani, M.D.,**
**Professor**
**of Pathology.**

**Theodore B. Schwartz M. D.,**
**Ass't. Attending Physician,**
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**Richard J. Winzler, Ph.D.,**
**Professor of Biological Chemistry**
**and Head of the Department.**

*Dr. Samter*: Today's Seminar, the first of a series of seminars on the problems of ageing, is held under the joint auspices of the Departments of Pathology and Medicine. It is in an attempt to define the physical process of ageing. A review of the literature suggests that little is known about ageing; and that it might be the function of the seminar to outline areas of needed research on ageing rather than to present established facts. The increasing age of the population has become one of the most immediate problems of this nation. It seems proper, therefore, to examine its physiological basis before we proceed in subsequent seminars to the complex and staggering problems of its management. Doctor Zimmerman has kindly agreed to moderate our symposium.

*Dr. Zimmerman*: A discussion of ageing might properly include socioeconomic, psychologic and physical considerations. Today we have been asked to consider the physiologic aspects. The intelligent discussion of any problem depends on a definition of that problem. Of the various proposed definitions, the two that are simplest are:

1) ageing represents a loss of functional reserve and
2) ageing is a process of unfavorable, retrogressive change, usually correlated with the passage of time and terminating on the death of the individual.

We should like to start our discussion today by asking Doctor Pirani to describe the morphologic aspects of these retrogressive changes.

*Dr. Pirani*: At the state of our present knowledge it is difficult, if not impossible to separate morphologically tissue changes due to "normal" ageing from some of those which can be referred to as "pathological". In many instances a clear-cut line of demarcation has not been established. This certainly applies to the vascular changes of ageing and those related to arteriosclerosis. Under conditions prevailing in this country, one might consider even deposition of lipids in the arterial wall as a "normal" event of ageing. Under a certain physical environment three main features of ageing stand out. First: tissue atrophy. The time of onset of this change is variable as is the rate for different organs. The size of the cells and probably their number, at least in some organs, decrease. These do not necessarily correlate. The number of factors related to this feature is probably great. I suspect that one of the most important ones is the amount of oxygen available to the tissues. Another important feature of ageing is the gradual and partial replacement of more differentiated tissues by less differentiated tissues. Examples of this phenomenon are the replacement of hematopoietic tissue by fat in the bone marrow and interstitial fibrosis that occurs in many organs. A third feature of ageing is the deposition of pigment, such as lipochrome, within cells and

**SEMINAR**
**of the**
**DEPARTMENT OF MEDICINE**
**of the**
**UNIVERSITY OF ILLINOIS**
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**Instructor in Medicine**

desposition of calcium in certain tissues, such as calcification of cartilage. The latter phenomenon is probably related to certain physicochemical changes in the ground substance of mesenchymal tissues.

*Dr. Zimmerman*: Dr. Catchpole, would you comment on such possible changes in the ground substance and connective tissue.

*Dr. Catchpole*: The connective tissue may be divided into two major sets of elements: a fibrillar portion, made up of reticulin, collagen and elastic fibers, and a non-fibrillar portion, the ground substance, together with electrolytes and water. It has been difficult to describe any real difference between reticulin and collagen, except a tinctorial one based on the staining of the former with silver. They appear to be identical in the electron microscope, and are at least chemically very similar. Some believe that collagen is merely condensed reticulin, or that the peculiar staining of reticulin is a function of the surrounding matrix. Recently, Hall and his colleagues, as reported in *Nature,* made the surprising observation that by treating collagen with enzymes they produced something that looked like elastic tissue in the electron microscope. Chemically, elastin and collagen are rather strikingly different. It is fairly safe to conclude that remarkable differences in these fibrillar elements have not been seen with ageing. Gross and Schmidt described no differences in the electron microscopic appearance of collagen obtained from individuals aged one hour and ninety years!

In the ground substance certain changes do occur with ageing. The ground substance of skin and of bone becomes less stainable with the periodic acid-leucofuchsin reagents with ageing; it apparently passes from a more to a less reactive state. With age, the quantity of ground substance is said to increase up to the 40th year, and then decrease. It is not clear what these changes mean. If the early growth changes of ground substance represent, as we have supposed, a gradual aggregation of its constituents, then ageing may represent a corresponding disaggregation. Laurie and Hastings found that the ageing of connective tissue involves, paradoxically, an uptake of water. This would be consistent with disaggregation, which would also imply the loss of certain soluble components with age. It would appear that some of the histological appearances described in ageing could be explained by increasing hydration of tissues.

Diffusible electrolytes are normally concentrated by the colloidal matrix (ground substance) of connective tissue; thus, magnesium and calcium are concentrated ten-fold as compared with blood. If disaggregation occurs with ageing, these ions may become released locally and could be precipitated as insoluble salts in an appropriate milieu.

*Dr. Pirani*: This could be explained by a loss of cellular water while the interstitial tissue water increases.

*Dr. Winzler*: There are a number of changes in the chemistry and metabolism of tissues as the organism ages. Unfortunately, most of these have been too inadequately studied to permit deductions to be made on their physiological significance. It may be important to emphasize that the ageing of the individual is really a summation of variable rates of ageing of the different tissues and organs.

One common change in tissue with age is a decrease in water content. Thus, brain, muscle and liver from old animals have a higher percentage of solids than from young animals. It is interesting that Doctor Catchpole reports that the water content of ground substance increases rather than decreases with age — a fact that may have considerable significance.

There also are changes in the hexosamine content of connective tissue with age, the amount falling quite significantly. This again may be correlated with an increase in water and a decrease in the insoluble components of ground substance.

Probably more important than change of chemical composition with age is the change of metabolism with age. A few such studies have been done. We have studied the *in vitro* consumption of oxygen by mouse brain of different ages, and have shown that the oxygen consumption is low at birth but rises markedly in the first few weeks.

When the rate of *in vitro* incorporation of radioactive phosphate into the nucleic acids and phospholipids was measured, however, the highest rates were obtained in the newborn mouse brain, and these rates declined steadily as the mice grew older. We also have measured the ca-

pacity of the brains from mice of different ages to support in vitro growth of Theiler's GD VII virus and found marked differences — the brain from newborn mice supporting growth but the brain of mice older than seven days being unable to do so.

Still another age difference that may be related to biochemical changes is the much greater "growth potential" of young tissues when they are transplanted into tissue culture. This difference in "growth potential" is probably at the very heart of the problem of ageing.

*Dr. Pirani*: We do know that cells of older individuals grow well in tissue culture. Under the proper conditions isolated cells and organs can be maintained in life indefinitely. One wonders whether this does not suggest an environmental factor.

*Dr. Zimmerman*: Doctor Schwartz, could any of the changes that have been described be related to hormonal factors? Is there any evidence for the concept that ageing might be related to changes in the endocrine glands?

*Dr. Schwartz*: I wish to emphasize that I believe the answers to these problems most likely will be obtained by the type of study described by Doctor Winzler. There are difficulties in considering the problem from the endocrine aspect. First, that which has been emphasized before, there are no concrete methods of separating normal ageing from the diseases that occur in later years. Second, the very important functional capacity of the endocrine glands, that is, their responsiveness, has not been well investigated and third, it is difficult to interpret the changes that are noted; it is difficult to decide whether they are salutary or harmful to the organism.

We can begin with the discussion of the gonads. The female of our species, differs from that of most other mammals in that while reproduction in other species can continue into old age, our species is unique in limiting the fertile period. This follows from the fact that the tissue that supplies the nutritive function for the egg is identical with the tissue that elaborates estrogenic hormones so that when the ovarian supply of eggs is exhausted the hormone secreting cells are no longer elaborated and the menopause ensues. In contrast in the male, in whom the production of androgen and the germ cells is independent and a dramatic climacteric is rare. On a statistical basis, 17-ketosteroid excretion in the male shows a rather characteristic curve with a sharp rise beginning at the time of puberty and a decline beginning at age 35 with the decline continuing gradually through the later years. Whether the later decline is due to a decrease in pituitary gonadotrophin or a failure of the interstitial cells to respond is not definitely known, but I would favor the latter possibility. It is true that in the male there is a varying degree of spermatogenic, tubular sclerosis, but it is questionable whether this is due to normal ageing and in addition there is no constant relationship between this change and the change in the interstitial cells.

In the pancreatic islets, again, there is an increase in incidence of diabetes with increase in age; but whether this is due to the ageing process itself or other stresses such as obesity, so common in our culture, it is difficult to say. The glucose tolerance test is relatively impaired in old non-diabetics, but this may again be the result of poor tissue response to adequate endogenous insulin rather than insulin deficiency.

With regard to the thyroid, the radioactive iodine uptake, the protein bound iodine level and the BMR tend to fall slowly and slightly with advancing years, but in general remain within what is considered to be the normal range.

Frank deficiency of the adrenal cortex is quite rare and the excretion of 17-hydroxycorticoids falls only slightly late in life. There is excellent documentation that the response of the adrenal cortex to ACTH continues to be quite brisk in old individuals.

Again, that is little definitive is known about the effect of ageing on the pituitary gland. That it remains responsive to target gland failure seems clear. The best example is the striking rise in gonadotrophin which occurs at the time of menopause with fall to normal in later years. Like the other endocrine glands, the hypophysis is sensitive to changes in the nutritive state and another factor which remains poorly evaluated is whether the endocrine changes that have been described are the result of poor nutrition in the aged. With regard to the parathyroid glands, the thymus, the pineal and adrenal medulla, no definitive data are at hand to warrant further discussion.

*Dr. Zimmerman*: In summary, ageing has been defined as a deleterious retrogressive change. It is characterized anatomically by changes in the vasculature which may represent "normal" ageing or a pathological concomitant of ageing, by decrease in parenchymal cells but increase in interstitial tissue of various organs and by the deposition of pigment and calcium in certain tissues. Histochemical changes in the ground substance seem to parallel measurable changes in its physiochemical state particularly the electrolyte, water, and polysaccharide composition of ageing tissues.

Measurable changes in the metabolism and an altered growth potential of tissues seem critical biochemical clues to the ageing process. There are some changes in endocrine function, particularly gonadal function, with ageing, but these have not been shown to have basic significance in the ageing process.

We hope that today's discussion has highlighted the types of questions to which we need answers.

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## Normal versus ulcer diet

The value of the dietetic treatment of peptic ulcer by means of bland foods has been assessed on 64 inpatients with gastric ulcer and on 80 outpatients with gastric ulcer and 50 inpatients with duodenal ulcer. The inpatients were divided into two equal groups: patients in one group were given the standard hospital ulcer diet, while in the other they were given an almost normal diet. The diets were strictly supervised throughout. The results showed a slight but statistically insignificant advantage to the patients on the almost normal diet with regard to the proportion in whom ulcer became completely healed (10/32 compared with 5/32) and the average amount healed for the whole group (70.3 per cent compared with 65.1 per cent), and (if patients on milk drip are omitted) a significant advantage in the average amount of weight gained (5 lb. 8 oz. compared with 2 lb. 14 oz.); on the other hand they showed an appreciable advantage to the patient on the standard ulcer diet with regard to the proportion who reported themselves completely free of pain throughout treatment (17/32 compared with 9/32.) The outpatients were advised either to continue for a year on the standard ulcer diet with which they previously had been treated or to revert to a wholly normal diet. At the end of the year the proportion who had remained free of pain and in whom the ulcer was radiographically healed was practically the same in the two groups (pain-free, 22 per cent and 21 per cent; ulcer healed, 45 per cent and 51 per cent). Dieting with bland foods does not increase the rate of healing in peptic ulcer. *R. Doll, M.D. Dietetic Treatment of Peptic Ulcer. Lancet, Jan.* 7, 1956.

# CASE REPORTS

# Prenatal Testicular Infarction

Stanley W. Thiel, M.D., Mattoon

A RECENT publication[1] concerning testicular infarction in the newborn, with a review of the literature, prompted this report of prenatal testicular infarction.

After a normal gestation period, a white male infant was delivered in a cephalic position without incident. At the time of delivery a scrotal mass was noted bilaterally. On examination it was noted that the mass on the right was fluctuant and easily transilluminated. A normal testicle could be palpated. The impression was that it was a hydrocele. The mass on the left was stony hard, about 2 x 2 x 3 cm. and nontender. It was attached to the scrotal sac at the lower pole and the skin overlying the mass had a bluish discoloration. No normal testicle could be found but the spermatic cord seemed normal. The remainder of the examination of the infant was within normal limits. No laboratory examinations were done.

It was felt that immediate surgical intervention was called for because the possibility of a malignancy of the testicle could not be ruled out. A surgical consultant, however, felt that surgery should be delayed for a period of observation. During this time the baby thrived and there was no change in the tumor. On the seventh day of life, the scrotum was opened and the testicle and spermatic cord exposed. The entire testicle and epididymis was a purple mass. The spermatic cord revealed no evidence of torsion and no discoloration. A small portion of the cord was removed with the testicle. The infant withstood the procedure well and made an uneventful recovery.

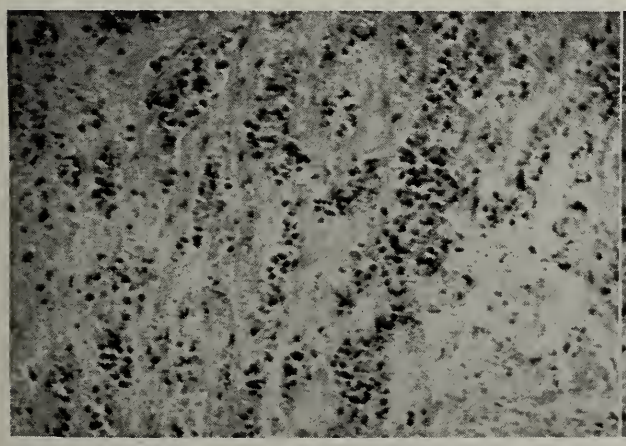


Figure 1. Testicular Infarct: Central area with necrosis and inflammatory infiltration.

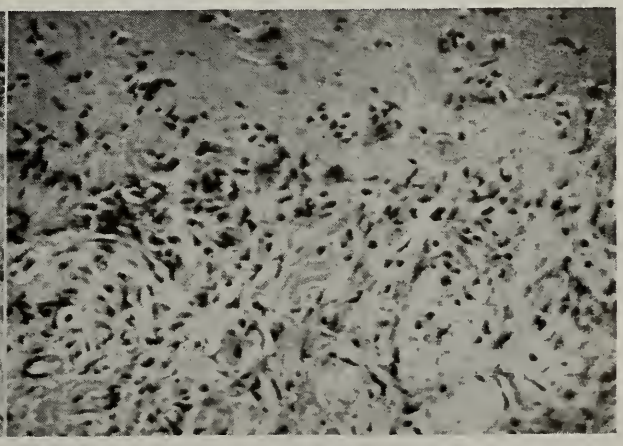


Figure 2. Testicular Infarct: Periphery with demarcating scar tissue.

### PATHOLOGICAL EXAMINATION

The specimen consisted of an egg-shaped testicle of moderately firm consistency and measured 30 x 18 x 30 mm. The external surface was covered with a somewhat bluish-red, smooth, intact membrane. On section, the architecture of the organ was indistinct and there was diffuse, dark-red discoloration present. Microscopically there was extensive necrosis of the testicular parenchyma. It was replaced by masses of erythrocytes, fibrin, and cellular debris. The cellular elements were not well preserved (Fig. 1). There was, adjoining the tunica albuginea, extensive formation of cellular granulation tissue and recent scar tissue (Fig. 2.) The larger blood vessels in the necrotic areas were often filled with thrombi. It was the pathologist's opinion that the infarction occurred 3-4 weeks before the specimen was removed.

### SUMMARY

Fourteen cases of testicular infarction in the newborn in the English literature is reported. This is the fifth case noted at delivery. Observation and pathological study indicate the infarction occurred in utero at least two weeks before delivery. The etiology of the infarction is obscure.

(The author is indebted to Doctor Aloysius Vass for the pathological study and photomicrographs.)

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## A new possibility

The right superior mammary gland of female dogs was injected with colloidal $Au^{168}$ in an effort to determine the localization of the isotope's concentration; the tolerance of the local site of injection; the effect of fractionated doses of the isotope; the intranodal distribution and radiation effect; and the factors influencing intranodal distribution. The isotope was found to concentrate in the right axillary, right latissimus dorsi, and cervical lymph nodes. There was never appreciable activity in other organs of the body. Mobilization of the colloid and concentration of radio-activity occurred within three hours after injection.

Radiation effect was present in lymph nodes receiving as little as 2 mc. of $Au^{198}$. Areas of necrosis appeared when 10 mc. or more were injected. Diffuse necrosis of all, or practically all, of the node did not occur until doses of the magnitude of 50 mc. were used. The local site of injection did not tolerate these large doses well and sloughs often occurred. Fractionated doses were tolerated somewhat better but did not produce comparable necrosis within the nodes. The effectiveness of this method of delivering ionizing radiations is dependent upon retaining diffuse distribution and irradiation within the lymph nodes. The distribution in turn appears to depend upon the amount of isotope used, the proximity of the injection site to the lymph nodes, and the patency of the afferent lymphatic channels. *Harold F. Berg, M.D. and William M. Christophersen, M.D. An Experimental Study of Intramammary Injection of $Au^{198}$. Ann. Surg. Jan.* 1956.

# Adenomatoid Tumor of the Epididymis

**Victor R. Jablokow, M.D., Evanston**

PRIMARY tumors of the epididymis are rather uncommon. Until 1949 Longo, McDonald and Thompson[1] were able to collect 134 tumors, 26% of which were malignant and 74% benign. The latter included 71 authentic cases of adenomatoid tumors. The authors discussed 19 additional cases. The so-called "adenomatoid" tumor is the most frequently encountered benign tumor of the epididymis. The term "adenomatoid" was suggested by Golden and Ash[2] and is most appropriate because of probable epithelial origin of the tumors. Since 1949, to the best of our knowledge, 12 additional cases have been reported[3-10].

A 57-year old white man was admitted because of repeated gastrointestinal hemorrhages due to duodenal ulcer. On general physical examination a mass was found in the right scrotal compartment. The patient stated that it had been gradually increasing in size for the past year. The mass was smooth, hard, freely movable and non-tender. It was apparently attached to the epididymis and was the size of a pea. There was no history of venereal disease, operation or trauma to the area.

Provisional diagnosis of spermatocele was made and the tumor was removed under local anesthesia. It had a diameter of 1.5 cm and was attached to the globus minor of the epididymis. The mass was separated from the surrounding structures without difficulty. Postoperative recovery was uneventful.

Gross appearance of the tumor was that of a well encapsulated, firm, slightly ovoid nodule measuring 1.5 cm. in diameter. Cut surface was glistening gray-white in color. Microscopically there were numerous empty gland-like spaces of various sizes lined by a single layer of predominantly flat cuboidal epithelial-like cells (Figure 1). The spaces were devoid of contents. Some of the cells had a vacuolated appearance. The stroma consisted of fibrous connective tissue, scanty in amount. Bundles of smooth muscle fibers were present. There were scattered aggregates of lymphocytes (Figure 2).

*Resident in Pathology, St. Francis Hospital, Evanston, Illinois*

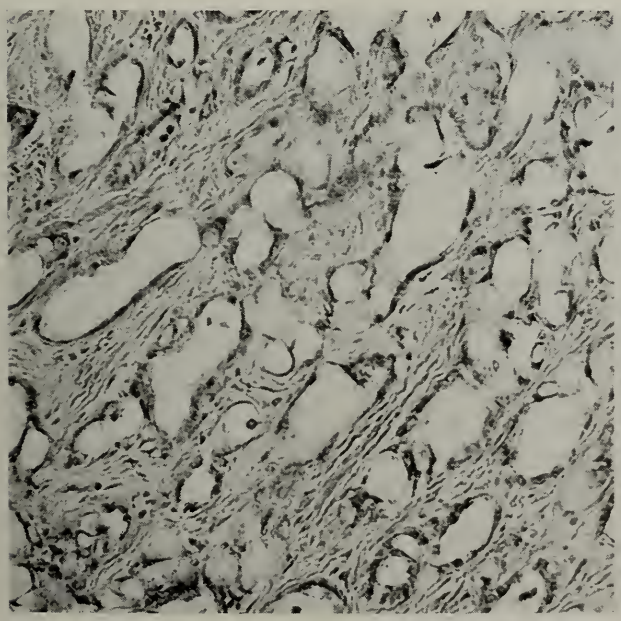


Figure 1. High magnification showing gland-like spaces in the ademato id tumor of the epididymis.

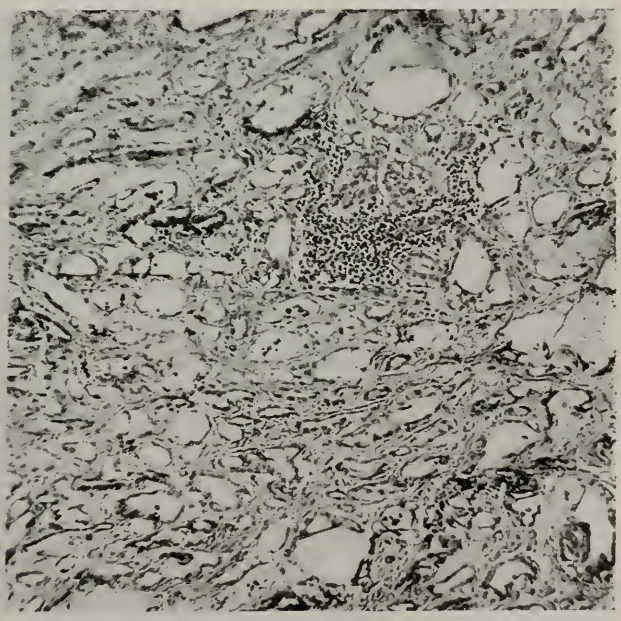


Figure 2. Low magnification showing aggregate of lymphocytes in the stroma.

## DISCUSSION

The "adenomatoid" tumors of the epididymis have been described under various names, such as mesothelioma, adenoma, adenomyoma, lymphangioma and even adenocarcinoma[9]. The tumors are usually firm, encapsulated, with gray-white to yellow cut surface which often shows a whorled pattern. They are always benign and no recurrences or metastases have been reported. They occur most commonly in the globus minor and average in size from 1.0 to 5.0 cm in diameter.

## SUMMARY

A case of adenomatoid tumor of the epididymis has been presented and discussed.

I am indebted to Dr. Edmund A. Petrus, Resurrection Hospital, Chicago, Illinois, for permission to publish this case.

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## Auditory habilitation

Every child suspected of having any hearing impairment should have the benefit of careful and thorough otological study as early as possible. It has been our sad experience to see not a few young persons of 16 to 18 years of age who had practically total nerve deafness, who had no intelligible speech, and of course no schooling. Not only were these youngsters objects of pity; they were burdens on society, incapable of self-support. Early recognition followed by rehabilitation would have made such a difference. It is encouraging to note an increasing awareness of this problem, not only on the part of physicians but with public health and school nurses as well as teachers. For the past two years we have conducted courses in audiology for nurses and teachers as part of the adult education program at Colby College. This course will be continued as we feel it cannot help but result in earlier recognition and definitive rehabilitation of these children. Our program of auditory rehabilitation at the Thayer Hospital was started eight years ago with a class of three: a 3 year old with complete absence of usable hearing due to meningitis, a 7 year old hard of hearing child, and a hard of hearing girl of 16 who was in an ungraded class at school because of lack of speech. Our classes have increased gradually until we now have 85 youngsters enrolled, many from distant parts of the state. *Elizabeth O. Koons, M.S. and Frederick T. Hill, M.D. Auditory Rehabilitation for the Deafened Child. J. Maine M.A. Feb.* 1956.

# EDITORIALS

## Vaginal examinations

The vaginal examination is a common office procedure yet little has been written on the proper technic. Many physicians have become calloused and forget milady's modesty and sensitivity. She ought to be draped and it is preferable to do this examination in the presence of another woman such as the nurse or office assistant.

A question and answer appeared in a recent issue of the British Medical Journal on the technic of the vaginal examination. The reply is well worth repeating:

"For the patient, the Sims' position usually is preferable. Tension at the introitus is reduced by the slight lumbar flexion and she may feel that modesty is better retained. For the examiner, the dorsal position usually is more efficient and muscular tension can be released if the knees are flexed and the sacrum is raised. A coverlet can reach below the knees. Although some women are not sentient in the vagina, in others, if the technic is not careful, erotic feelings will be aroused and this can cause great offense.

"The vagina normally has little sensation to an incoming object, provided it is moved slowly. One finger can enter first, yielding to the contour of the vaginal wall, and the other finger can then enter slowly and almost without further contact with the mucosa. Provided the fingers are withdrawn slowly, no erotic sensation is likely to be induced. Care also should be taken not to press against the vulva with the thumb. Many students are unaware of these facts and, having made their examination, withdraw their fingers too hastily. Not uncommonly, at such a moment, the patient inspires and flushes and is clearly offended. Some practitioners appear to evade such difficulties by a firm and even rough examination but this is equally undesirable. Often such methods will be met with a resisting spasm which the patient is likely to adopt on subsequent examinations.

"If water-soluble lubricants are used — and they help greatly to make the examination more comfortable — the vulva should always be dried afterward. It is extremely unpleasant for a woman to have to walk home with a lubricated introitus. In some hospital departments, a clean towel is provided for the patient to dry herself; otherwise the examiner should remove the lubricant with swabs. The examiner who takes trouble over these small details often is surprised by the patient's gratitude."

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## Salk vaccine

The National Foundation for Infantile Paralysis announces its recommended 1956 emergency, or compromise dosage schedule for the Salk polio vaccine for patients coming into the physician's private practice.

1. Do not give booster shots between now and July 1. There is minimal risk if, in fact, any at all, in giving primary or booster shots during the polio season.

2. Use all available vaccine immediately. Do not save it for second shots, even though a sterilely punctured vial of vaccine can be kept

under refrigeration for an indefinite length of time without impairing either safety or potency of the vaccine.

3. The increasing supply of vaccine should be depended upon for second injections in 1956. The exact interval recommended between the first and second doses is not critical, so long as it is not less than two weeks. In fact, longer intervals seem to be advantageous. Therefore, the second dose may be given at any time without losing the benefit of the first.

4. However, the third dose should be given not less than seven months after the second but may be given at any time thereafter.

In the Foundation's opinion, this vaccination will become a standard procedure, with a schedule of injections beginning at 6 to 9 months of age.

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## If the shoe fits

In "an editorial of sorts"[1] J. M. Steele describes the debunking activities of Sir Thomas Browne, which occurred 300 years ago. But Steele cautions modern physicians not to be smug because old wives' tales, whether lay or medical, are slow to die. Steele offers the following examples for mid 20th century consideration:

"That an electrocardiogram will diagnose everything pertaining to the heart, from mitral insufficiency to interventricular septal defects;

"That a depressed hemoglobin calls for combined therapy with liver, vitamins B12 and B complex, cobalt, and even iron;

"That adhesions are a common cause for the persistent abdominal discomfort of the much laparotomized patient;

"That most asthmatic children will outgrow it if you just leave them alone."

Some adages, not so old, are:

"That penicillin is an innocuous drug, very valuable in aborting a cold;

"That cortisone or related steroids are the preferred symptomatic treatment for nearly everything."

I have one of my own to add: "Give penicillin. If the patient is not well in three days, examine him." This has been said in jest on many occasions but is not humorous. We suspect that some physicians in many communities make a practice of it.

[1]J. M. Steele: Guthrie Clin. Bull. 25:3 (Jan.) 1956.

## PR dinner cancelled

The Committee on Medical Service and Public Relations has cancelled the annual Public Relations dinner, which had been scheduled for Tuesday evening May 15, in favor of an all-day PR Conference to be held in the early Fall. It is the feeling of the Committee that county society public relations chairmen and committee members will gain more from a session devoted entirely to medical public relations problems than they would from a primarily social function held in connection with the annual meeting of the Illinois State Medical Society.

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## Contribution of manuscripts

Manuscripts should be submitted in duplicate — original and one copy. They should be typewritten, double spaced and limited to a maximum of 3,000 words.

Authors assume sole responsibility for statements, conclusions and methods of presenting their subject as these may not always be in accord with views of the Editorial Board. It is the desire to give authors as wide a latitude as the policies of the Illinois Medical Journal and space will permit. The right to reduce, revise or reject any manuscript is reserved.

Articles are accepted on condition that they are submitted for exclusive use in this Journal. Notices of acceptance or rejection normally should be received by the author within 60 days. Every effort will be made to return unused manuscripts promptly.

Footnotes and references should conform to the style of Quarterly Cumulative Medicus, published by the A.M.A. The order follows: name of author, title of article, name of periodical, with volume, page, month (day of month if weekly) and year. The month and date of month should be set in brackets—i.e. [Apr. 23]. The Journal assumes no responsibility for accuracy of these references.

A reprint order form will be sent to the author upon acceptance of a manuscript for publication.

Manuscripts should be sent to Harold M. Camp, M.D., Editor of The Illinois Medical Journal, 224 So. Main St., Monmouth, Illinois.

# Official Program

**for the**

**One Hundred Sixteenth**

# Annual Meeting

**of the**

# Illinois State Medical Society

**May 15, 16, 17, 18, 1956**

**Hotel Sherman** **Chicago**

# PROGRAM SUMMARY

## TUESDAY, May 15, 1956

7:30 Council Breakfast, Jade Room 103

9:00 Section on Eye, Ear, Nose and Throat, Crystal Room
Section on Cardiovascular Disease, Gold Room 114
Section on Anesthesiology, Emerald Room 104
Section on Obstetrics & Gynecology, Old Chicago Room 101

9:00 First Meeting — House of Delegates, Louis XVI Room

12:00 Luncheon, Section on Anesthesiology, Jade Room 103

1:30 General Assembly, The Ballroom

3:30 Section on Radiology, Crystal Room

9:00 Program and Buffet Supper — In co-operation with Woman's Auxiliary, Bal Tabarin

## WEDNESDAY, May 16, 1956

8:00 Council Breakfast, Jade Room 103

9:00 Section on Pediatrics, Louis XVI Room
Section on Eye, Ear, Nose and Throat, Crystal Room
Section on Surgery, Old Chicago Room 101
Physicians Association, Dept. of Public Welfare, Gold Room 114

10:00 Reference Committees
1. Reports of Officers, Time Room 110
2. Reports of Councilors, Gold Coast 111
3. Standing Committees, Orchid Room 106
4. Reference Committee "A", Holiday Room 105
5. Reference Committee "B", Emerald Room 104
6. Reference Committee "C", Jade Room 103

12:00 Illinois Chapter, American Academy of Pediatrics, Louis XVI Room
Fifty Year Club Luncheon, Crystal Room

11:45 Illinois Chapter, American Academy of General Practice luncheon, Assembly Room

1:30 General Assembly, The Ballroom

7:00 Annual Dinner, The Ballroom

## THURSDAY, May 17, 1956

8:00 Council Breakfast, Jade Room 103
Women Physicians' Breakfast, Emerald Room 104

9:00 Section on Preventive Medicine & Public Health, Louis XVI Room
Section on Allergy, Crystal Room
Section on Medicine, Gold Room 114
Section on Dermatology, Old Chicago Room 101

10:00 Illinois Chapter, American College of Chest Physicians, Ruby Room 113

10:00 Reference Committees
1. Reference Committee "D", Jade Room 103
2. Reference Committee "E", Orchid Room 106
3. Miscellaneous Business, Holiday Room 105

12:00 Luncheon, Illinois Chapter, American College of Preventive Medicine, Louis XVI Room
Luncheon, Illinois Chapter, American College of Chest Physicians, Emerald Room 104
Luncheon, Section on Dermatology, Old Chicago Room 101
Luncheon — Phi Chi Fraternity, Room 107

1:30 General Assembly, The Ballroom

3:00 Second Meeting — House of Delegates, Louis XVI Room

7:00 Loyola Alumni Dinner, The Crystal Room

## FRIDAY, MAY 18, 1956

8:30 Third Meeting — House of Delegates, Louis XVI Room

9:00 Section on Pathology, Crystal Room
Red Cross Disaster Program, Chicago Room 101

12:00 Luncheon — Section on Pathology, Crystal Room

12:30 Council Luncheon, Gold Room 114

2:00 Illinois Association of Blood Banks, Louis XVI Room

# Meetings of the House of Delegates

## Louis XVI Room

### (1) Tuesday, May 15, 1956

9:00 a.m.

The first meeting of the House of Delegates will be called to order by the President, F. Garm Norbury for:
The appointment of Reference Committees
The Reports of Officers, Councilors, Committees, etc.
The introduction of Resolutions, and for the transaction of any other business which may come before the House
THE COMMITTEE ON CREDENTIALS will meet at 8:00 a.m. Tuesday morning, May 15, in the entrance way to the Louis XVI Room. Delegates desiring to be certified as the official representatives of their county medical societies must present their credential cards to this committee

### (2) Thursday, May 17

3:00 p.m.

The Second meeting of the House of Delegates will be called to order by the President to hear those reports of Reference Committees ready to be presented.

### (3) Friday, May 18

8:30 a.m.

The third (and last) meeting of the House of Delegates will be called to order by the President to hear those reports of Reference Committees remaining to be presented;
For the Election of Officers, Councilors, Committees, Delegates and Alternates to the American Medical Association, and for the transaction of any other business to come before the House.
At the close of this last meeting, F. Lee Stone will be installed as the new President of the Illinois State Medical Society, and will receive the official gavel from the retiring President, F. Garm Norbury.

# Programs For Tuesday, May 15, 1956

## SECTION ON EYE, EAR, NOSE AND THROAT

Chairman ..... Fletcher Austin, Chicago
Secretary ..... G. LeRoy Porter, Urbana

CRYSTAL ROOM

Tuesday Morning May 15, 1956

9:00 "The Evolution of Stapes Mobilization Surgery"
EUGENE L. DERLACKI, Assistant Professor of Otolaryngology, Northwestern University Medical School, Chicago
9:20-9:30 Discussion

9:30 "Progress in the Control of Retrolental Fibroplasia in Illinois"
J. ROBERT FITZGERALD, Supervising Ophthalmologist, Illinois Public Aid Commission; Assistant Professor of Ophthalmology, Stritch School of Medicine, Loyola University, Chicago
9:50-10:00 Discussion

10:00 "Hemorrhage Following Otolaryngologic Surgery"
WILLIAM H. WEISS, Springfield
10:20-10:30 Discussion

10:30 "Medical Ophthalmoscopy Clinic" — (Illustrated)
HENRY P. WAGENER, Emeritus Consultant in Ophthalmology, Mayo Clinic, Rochester, Minnesota
11:00-11:15 Discussion

11:15 BUSINESS MEETING and Election of 1956 Section Officers
Section Officers

11:30 ADJOURNMENT TO VIEW EXHIBITS

## SECTION ON CARDIOVASCULAR DISEASE

Chairman ..... Chauncey C. Maher, Chicago
Secretary ..... Emmet F. Pearson, Springfield

GOLD ROOM 114

Tuesday Morning, May 15, 1956

9:00 "The Heart in Poliomyelitis"
GERSHOM K. GREENING, Springfield

9:20 "Prevention of Myocardial Infarction"
OGLESBY PAUL, Chicago

9:40 "High Blood Pressure vs. Hypertensive Disease"
JESSE C. LOCKHART, Peoria

10:00 RECESS TO VIEW EXHIBITS

10:30 "The Coronary Artery Reconsidered"
E. GREY DIMOND, Kansas City, Kansas

11:15 "Extra Cardiac 'Heart Attacks' "
EARLE GRAY, Chicago

11:35 "Question and Answer Period
E. GREY DIMOND
GERSHOM K. GREENING
OGLESBY PAUL
JESSE C. LOCKHART
EARLE GRAY

11:50 BUSINESS MEETING and Election of 1957 Section Officers.

## SECTION ON ANESTHESIOLOGY

Chairman ..... Arthur T. Shima, Oak Park
Secretary ..... E. M. Dewhirst, Danville
Alternate ..... Mary Karp, Chicago

EMERALD ROOM 104
Tuesday Morning, May 15, 1956

9:00 Opening of the Section meeting

9:10 "Nitrous Oxide, Cyclopropane Anesthesia"
BRYCE OZANNE, Moline

9:40 "Problems in Anesthesia of the Aged"
PAUL H. LORHAN, Professor of Surgery (Anesthesiology) and Chief, Section of Anesthesiology, University of Kansas School of Medicine, Kansas City

10:10 RECESS TO VIEW EXHIBITS

10:40 "Anesthesia for Emergency Surgery in Children"
ROBERT M. SMITH, Children's Medical Center, Boston, Massachusetts

11:10 "Pain"
F. A. DUNCAN ALEXANDER, Associate in Anesthesia, State University of Iowa, University Hospitals and Veterans Administration Hospital, Iowa City

11:40 Business meeting for the election of 1957 Section Officers.

12:00 Section Luncheon, Jade Room No. 103

## SECTION ON OBSTETRICS AND GYNECOLOGY

Chairman ..... Charles D. Krause, Chicago
Secretary ..... Carl Greenstein, Champaign

OLD CHICAGO ROOM 101
Tuesday Morning, May 15, 1956

9:00 "Pelvic Tumors Complicating Pregnancy"
HENRY A. LATTUADA, Attending Obstetrician and Gynecologist Lakeview Hospital, Danville

9:20 "Recent Impressions Concerning Diseases of the Ovaries"
BRADLEY SYLVESTER, Attending Obstetrician & Gynecologist, St. Joseph's Hospital, Joliet

9:40 "Air Embolism Associated with Pregnancy"
JACK D. BRODSKY, Attending Obstetrician and Gynecologist, Burnham City Hospital, Champaign

10:00 RECESS TO VIEW EXHIBITS

10:30 PANEL DISCUSSION: "Obstetrical Hemorrhage"
Moderator: WILLARD C. SCRIVNER, Attending Obstetrician and Gynecologist, St. Mary's Hospital, East St. Louis.
FREDERICK H. FALLS, Chicago
WILLIAM J. DIECKMANN, Chicago
HUBERT L. ALLEN, Alton
WILLIAM COOLEY, Jr., Peoria

11:30 Business Meeting and Election of 1957 Section Officers.

## SECTION ON RADIOLOGY

Chairman ..... Fred H. Decker, Peoria
Secretary .... Hildegarde A. Schorsch, Chicago

CRYSTAL ROOM
Tuesday Afternoon, May 15, 1956

3:30 p.m.

Guest moderator of the film reading session of the Section on Radiology will be CHESTER H. WARFIELD, Director of the Department of Radiology at St. Joseph's Hospital, Fort Wayne, Indiana. He is also Consultant Radiologist at the Veterans' Hospital in Fort Wayne.

Following the scientific portion of the program, a business meeting and the election of Section Officers for 1957 will be held.

# General Assembly

THE BALLROOM

Tuesday Afternoon, May 15, 1956

Presiding: ..... Charles D. Krause, Chicago
Assisting: ..... Fred H. Decker, Peoria

1:30 Opening of the General Assembly
F. GARM NORBURY, Jacksonville. President, Illinois State Medical Society

1:40 "Roentgen Evaluation of the Chest"
CHESTER H. WARFIELD, Fort Wayne, Indiana. Director, Department of Radiology, St. Joseph's Hospital Consultant Radiologist, Veterans Hospital of Fort Wayne

2:00 "Urinary Incontinence in the Female"
JOHN C. ULLERY, Columbus, Ohio. Professor and Chairman of Department of Obstetrics and Gynecology, Ohio State University College of Medicine

2:20 "Anesthetic Consideration in the Acutely Injured Patient"
HARVEY C. SLOCUM, Colonel, USA MC, Washington, D.C. Chief Consultant in Anesthesia to the Surgeon General, Chief of Anesthesia and Operating Section, Walter Reed Army Hospital

2:40 RECESS TO VIEW EXHIBITS

Presiding: ..... Fletcher Austin, Chicago
Assisting: ..... Arthur T. Shima, Oak Park

3:30 "Acute Coronary Occlusion Reconsidered"
E. GREY DIMOND, Kansas City, Kansas Professor of Medicine and Head of Department of Medicine, University of Kansas School of Medicine

3:50 "Gamma Globulin in Disease"
ROBERT GOOD, Minneapolis, Minnesota, Director of Pediatric Research, University of Minnesota Medical School

4:10 "Physiology of Transient Loss of Vision"
HENRY P. WAGENER, Rochester, Minnesota, Emeritus Consultant in Ophthalmology, Mayo Clinic.

***Here's an interesting and entertaining evening planned just for you —***

**PROGRAM AND BUFFET SUPPER**

BAL TABARIN

Tuesday Evening, May 15, 1956

7:00 p.m.

Instead of the Hospitality Hour scheduled on Tuesday evening in former years, the WOMAN'S AUXILIARY to the Illinois State Medical Society, working with the Liaison Committee from the State Society headed by Dr. Frederic M. Nicholson of Chicago, are planning a program and buffet supper.

The Auxiliary has planned several "skits" and the general theme of their evening program will be to honor the physicians with whom they have worked during the past year.

Mrs. Nicholas G. Chester of Oak Park is the Chairman selected by the Auxiliary to plan the evening's entertainment.

# Programs For Wednesday, May 16, 1956

## SECTION ON PEDIATRICS

Chairman ..... J. Keller Mack, Springfield
Secretary ..... Noel G. Shaw, Evanston
LOUIS XVI ROOM
Wednesday Morning, May 16, 1956
Joint Meeting with Section on Medicine

9:00 "Jaundice in the Newborn"
HAROLD D. PALMER, Pathologist, St. John's Hospital, Springfield

9:20 "Treatment of Burns in Children" (Kodachromes)
FRANK PIRRUCCELLO, St. Francis Hospital, Evanston

9:40 "Experience with Salk Vaccine in Illinois in 1955"
RUTH CHURCH, Chief, Bureau of Communicable Disease Control, State Department of Public Health, Springfield.

10:00 "Reticuloendotheliosis in Children"
HEYWORTH N. SANFORD, Chairman, Department of Pediatrics, University of Illinois College of Medicine, Chicago.

10:20 RECESS TO VIEW EXHIBITS

10:50 SYMPOSIUM ON THE USE OF STEROIDS
Moderator: JOHN S. BIGLER, Medical Director, Children's Memorial Hospital, Chicago
"The Uses and Abuses of ACTH and Cortisone in Children"
ROBERT GOOD, Director of Pediatric Research, University of Minnesota College of Medicine, Minneapolis.
"Steroids in the Treatment of Nephrosis"
SMITH FREEMAN, Professor of Biochemistry, Northwestern University Medical School, Chicago
"The Use of ACTH and Cortisone in Rheumatic Fever"
GENE STOLLERMAN, Northwestern University Medical School, Chicago

12:15 BUSINESS MEETING, and Election of Section officers of 1957.

12:30 LUNCHEON — Illinois Chapter, American Academy of Pediatrics.
All physicians interested in problems and welfare of children are invited to attend.

## SECTION ON EYE, EAR, NOSE AND THROAT

Chairman ..... Fletcher Austin, Chicago
Secretary ..... G. LeRoy Porter, Urbana
CRYSTAL ROOM
Wednesday Morning, May 16, 1956

9:00-11:30
SYMPOSIUM: NEUROLOGIC COMPLICATIONS OF EYE, EAR, NOSE AND THROAT
MODERATOR: DERRICK T. VAIL, Professor and Head of the Department of Ophthalmology, Northwestern University Medical School, Chicago
PANEL: "Clinical Aspects of Neuralgia of the Head" ROLOND P. MACKAY, Professor of Neurology, University of Illinois College of Medicine, Chicago "Cerebral Angiography from Viewpoint of the Neurosurgeon".
JOSEPH P. EVANS, Professor of Neurological Surgery, University of Chicago School of Medicine, Chicago "Clinical Lesions of the Oculomotor Nerve."
JOSEPH E. ALFANO, Clinical Assistant in Ophthalmology, University of Illinois College of Medicine, Chicago "Cerebral Angiography"
FAY H. SQUIRE, Clinical Professor of Radiology (Rush), University of Illinois College of Medicine, Chicago "Neurological Complications from Otolaryngologic Aspect"
BURTON J. SOBOROFF, Assistant Professor of Otolaryngology, University of Illinois College of Medicine, Chicago

11:30 ADJOURNMENT TO VIEW EXHIBITS

## SECTION ON SURGERY

Chairman ..... Cornelius M. Annan, Chicago
Secretary ..... David A. Bennett, Canton
OLD CHICAGO ROOM 101
Wednesday Morning, May 16, 1956

9:00 "A New Technique in the Management of Severe Pelvic Fractures"
WILLIAM JOHNSON, Galesburg Clinic, Galesburg.

9:15 "Surgical Treatment of Pulmonary Cysts and Spontaneous Pneumothorax"
ROBERT A. DeBORD, Surgical Staff, St. Francis Hospital, Peoria

9:30 "Vascular Problems Encountered in Abdominal Surgery"
JAMES S. CLARKE, Assistant Professor of Surgery, University of Chicago School of Medicine, Chicago

9:45 "Pitfalls in Abdominal Surgery"
HARRY A. OBERHELMAN, Professor and Chairman, Department of Surgery, Stritch School of Medicine, Loyola University; Mercy Hospital, Chicago.

10:00 RECESS TO VIEW EXHIBITS

10:30 PANEL DISCUSSION ON GALL BLADDER DISEASE
MODERATOR: WARREN H. COLE, Professor and Head of Department of Surgery, University of Illinois College of Medicine; Illinois Research Hospitals, Chicago
Collaborators:
EVERETT P. COLEMAN, Coleman Clinic, Graham Hospital, Canton
ARKELL M. VAUGHN, Clinical Professor of Surgery, Stritch School of Medicine, Loyola University; Senior Surgeon, Mercy Hospital, Chicago
WALTER G. MADDOCK, Professor of Surgery, Northwestern University Medical School; Wesley Memorial Hospital, Chicago
L. S. HELFRICH, Moline

11:45 Business Meeting and Election of 1957 Section Officers.

## THE PHYSICIANS' ASSOCIATION

of the
Department of Public Welfare,
State of Illinois
GOLD ROOM 114
Wednesday Morning, May 16, 1956

J. W. Klapman, President, Chicago
S. J. Lipnitzky, Secretary-Treasurer, Dixon
Werner Tuteur, Program Director, Elgin

1. "The Autonomic Nervous System and Immunity"
S. LOUMOS, M.D.
2. "Carbon Dioxide in the Treatment of Neurotic Disturbances"
ROCHUS STILLER, M.D.
3. "A Case of Fatal Agranulocytosis due to Chlorpromazine"
WERNER TUTEUR, M.D.
4. "Availability of Hostile Fantasy Related to Overt Behavior"
5. "Jujunal Motility Patterns"
A. J. Glazebrook
6. "A Study in the Validation of the Lie Scale"
Mr. E. Kurtz, psychologist at Manteno.
PAUL KANE, Ph.D.

## FIFTY YEAR CLUB LUNCHEON

CRYSTAL ROOM

Wednesday Noon, May 16, 1956 12:00

Andy Hall, Chairman of the Fifty Year Club since its formation in 1937, will preside again this year at the annual complimentary luncheon honoring the members of the FIFTY YEAR CLUB.

All physicians who have been in the practice of medicine for fifty years or more are invited as guests of the Illinois State Medical Society at one of the most popular social functions held during the annual meeting.

Tickets for the luncheon are complimentary and may be secured at the ticket desk during the first day of the meeting, or from Doctor Hall.

## ILLINOIS ACADEMY OF GENERAL PRACTICE

The Assembly Room

Wednesday Noon, May 16, 1956

There will be a luncheon meeting of the Illinois Academy of General Practice at 11:45 o'clock on Wednesday, May 16, 1956, in the Assembly Room on the mezzanine floor of the Hotel Sherman.

Since this meeting must adjourn at 1:15 in order that the physicians in attendance may be present in the General Assembly by 1:30, the luncheon will start on time, as listed.

Members of the Academy and their friends may make their reservations now with their Regional Chapter Secretary.

It is hoped that the first meeting of the Illinois Academy of General Practice to be held in connection with the annual meeting of the Illinois State Medical Society will be a successful one.

# General Assembly

THE BALLROOM

Wednesday Afternoon, May 16, 1956

Presiding: ..... J. Keller Mack, Springfield

Assisting: ..... Fred Long, Peoria

1:30 THE PRESIDENT'S ADDRESS: "Medicine: An Art and A Science"
F. GARM NORBURY, Jacksonville. President, Illinois State Medical Society

1:50 THE ORATION IN SURGERY: "The Functional Nature and Clinical Significance of Some Thyroid Tumors"
BROWN M. DOBYNS, Cleveland, Ohio. Professor of Experimental Surgery, Western Reserve University School of Medicine

2:20 THE ORATION IN MEDICINE: "Streptococcal Infection, Rheumatic Fever, and Nephritis"
CHARLES H. RAMMELKAMP, Cleveland, Ohio. Professor of Medicine and Public Health, Western Reserve University School of Medicine

2:50 RECESS TO VIEW EXHIBITS

Presiding: ..... Cornelius M. Annan, Chicago

Assisting: ..... David A. Bennett, Canton

3:10 SYMPOSIUM ON PREVENTION AND TREATMENT OF AUTOMOBILE ACCIDENTS

1. "The Auto Crash Injury Research Program" — five minute review.
SERGEANT ELMER C. PAUL, Supervisor of Auto Crash Injury Research Section, Indiana State Police, Indianapolis, Indiana

"Causes of Occupant Injuries" narration with slides
SERGEANT PAUL

2. "The Search" — black and white film showing results of CORNELL UNIVERSITY RESEARCH DIVISION on crash injuries and results of field and laboratory studies. Runs 27 minutes.

3. "Drivers, Drinks and Drugs"
W. J. R. CAMP, M.D., Ph.D., Chicago. Professor of Pharmacology and Toxicology, University of Illinois School of Medicine. State Toxicologist.

4. "The Immediate Care of Maxillofacial Injuries"
WAYNE B. SLAUGHTER, D.D.S., M.D., Chicago. Chairman, Department of Plastic Surgery, Stritch School of Medicine, Loyola University

5. "Injuries of the Lower Urinary Tract"
WILLARD EASTON, Peoria

**THE ANNUAL DINNER**

THE BALLROOM

Wednesday, May 16, 1956

7:00 p.m.

Arkell M. Vaughn, Immediate Past President ... ..... Toastmaster

Invocation: Rev. Fred Hoskins, D.D. Pastor, 1st Congregational Church, Oak Park

Guest Speaker: "The Human Side of Medicine" ELMER HESS, President, American Medical Association, Erie, Pennsylvania

Introduction of Past Presidents and Guests ... ..... Arkell M. Vaughn

Presentation of President's Certificate to F. GARM NORBURY .... By Joseph T. O'Neill Chairman of the Council

Dinner Music

# Programs For Thursday, May 17, 1956

## WOMEN PHYSICIANS' BREAKFAST

EMERALD ROOM 104

Thursday Morning, May 17, 1956

8:00 a.m.

On Thursday morning, May 17, the Women Physicians registered at the 1956 annual meeting will be the guests of the Illinois State Medical Society at a breakfast meeting.

This annual breakfast has been held for several years, and the women physicians in attendance have enjoyed a complimentary breakfast and short and informal program before the scientific sessions for the day open at 9:00 a.m.

Dr. Elizabeth R. Fischer, of Chicago is the Chairman for this year's meeting.

## SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

Chairman ..... Fred Long, Peoria
Secretary ..... Herbert Ratner, Oak Park

LOUIS XVI ROOM

Thursday Morning, May 17, 1956

9:00 a.m.

"Host-Contaminant Relationships"
PROF. JAMES A. REYNIERS, Research Professor of Bacteriology, Director of Lobund Institute University of Notre Dame, Notre Dame, Indiana

"Vital Statistics and the Etiology of Heart Disease"
JEREMIAH STAMLER, Assistant Director of Cardiovascular Department, Medical Research Institute, Michael Reese Hospital; Established Investigator of the American Heart Association, Chicago

"Tuberculosis Control in 1956"
EDWARD A. PISZCZEK, Suburban Cook County Tuberculosis Sanatorium District; Professor of Preventive Medicine and Public Health, Stritch School of Medicine, Loyola University, Chicago.

11:45 BUSINESS SESSION and Election of 1957 Section Officers.

12:00 Adjournment.

## SECTION ON ALLERGY

Chairman .....Milton M. Mosko, Chicago
Secretary .....Leonard Harris, Peoria

CRYSTAL ROOM

Thursday Morning, May 17, 1956

9:00 a.m.

1. "Why is Asthma Frequently Worse from October through Christmas?"
HARRY LEE HUBER, Chicago
2. "The Management of Allergic Diseases without Antihistaminics, Adrenal Steroids or Antibiotics"
ESTHER PIZER, Chicago Medical School, Chicago
3. "The Complications of Adrenal Steroid Therapy in Actual Practice" (The Results of a questionnaire).
ALAN R. FEINBERG, Northwestern University Medical School, Chicago
4. "How Important are Emotional Factors in Allergic Diseases of Children?" A SYMPOSIUM
HENRY FEINBERG, Northwestern University
TOWNSEND FRIEDMAN, Northwestern University
JOHN HYDE, University of Illinois
HOWARD LEE, Marquette University

Business Meeting and election of Section Officers for 1957.

## SECTION ON MEDICINE

Chairman ..... Jacques M. Smith, Chicago
Secretary ..... Robert M. Hoyne, Urbana

GOLD ROOM 114

Thursday Morning, May 17, 1956

SECTION ON PEDIATRICS — By Invitation.

9:00 SYMPOSIUM ON ANTIBIOTICS
MODERATOR: HARRY F. DOWLING Professor of Medicine, and Head of Department, University of Illinois College of Medicine, Chicago
PAUL S. RHOADS, Professor of Medicine, Northwestern University Medical School; Chief of Medicine Wesley Memorial Hospital, Chicago
L. MARTIN HARDY, Representing the Section on Pediatrics, Associate Professor of Pediatrics, Northwestern University Medical School, Chicago.

10:00 RECESS TO REVIEW EXHIBITS

10:30 "Recent Developments in Hepatitis"
RICHARD B. CAPPS, Professor of Medicine, Northwestern University Medical School, Chicago

11:00 "Psychiatric Problems Encountered in Adolescence"
VIRGINIA TARLOW, Associate Professor of Psychiatry, University of Illinois College of Medicine, Chicago

11:30 Business Meeting and Election of 1957 Section Officers.

## SECTION ON DERMATOLOGY

Chairman .... James Herbert Mitchell, Chicago
Secretary ..... Malcolm Spencer, Danville

OLD CHICAGO ROOM 101
Thursday Morning, May 17, 1956

SYMPOSIUM — THE MANAGEMENT OF COMMON SKIN DISEASES

9:30 "Some Disorders of the Scalp"
JAMES HERBERT MITCHELL, Chicago. Chairman, Section on Dermatology

10:00 "The Skin: An Index of Visceral Changes"
WILLIAM K. FORD, Rockford
Discussant: Jerome Sickley, LaSalle

10:30 "The Changing Outlook of Pemphigus"
SAMUEL M. BLUEFARB and LEONARD HOYT, Chicago
Discussant: Richard B. Stoughton Chicago

11:00 RECESS TO VIEW EXHIBITS

11:30 PANEL: "The Management of the Scaling Eruptions"
The panel will stress the treatment of the following: Psoriasis, Seborrheic Dermatitis, Pityriasis Rosea and Lichen Planus.

Kodachromes of examplary cases will be presented for discussion.

MODERATOR: James Herbert Mitchell, Chairman, Section on Dermatology
Hans M. Buley, Christie Clinic, Champaign
John M. McCuskey, Peoria
Hilliard M. Shair, Physicians and Surgeons Clinic, Quincy
John H. Lamb, Oklahoma City, Guest of the Section on Dermatology.

12:30 LUNCHEON for members of the Section and their guests.
BUSINESS MEETING and election of 1957 Officers for Section on Dermatology

## Illinois Chapter AMERICAN COLLEGE OF CHEST PHYSICIANS

RUBY ROOM 113

Thursday Morning, May 17, 1956

10:00 a.m.

PANEL DISCUSSION: "The Problem of the Patient with Irremovable Pulmonary Carcinoma"

MODERATOR: WILLIAM M. LEES, Chief of Surgery, Municipal Tuberculosis Sanatorium, Chicago. Associate Professor of Surgery, Stritch School of Medicine, Loyola University, Chicago.

Panel Members

HAROLD C. VORIS, Professor of Neurosurgery, Stritch School of Medicine, Loyola University, Chicago

LEWIS HAAS, Associate Professor of Radiology, University of Illinois College of Medicine, Chicago

MARC H. HOLLENDER, Chief of Liaison Service, Neuropsychiatric Institute, University of Illinois College of Medicine, Chicago.

WILLIAM WALSH, Chief of Tumor Service, Hines Veterans Administration Hospital, Hines.

ROBERT O. LEVITT, Assistant Professor of Medicine, University of Illinois College of Medicine, Chicago

12:00 LUNCHEON in The Emerald Room No. 104

Brief business meeting with adjournment at 1:15 p.m.

## LUNCHEON
## Illinois Chapter AMERICAN COLLEGE OF PREVENTIVE MEDICINE

LOUIS XVI ROOM

Thursday noon, May 17, 1956

Dr. Felix A. Thornabene has announced that the speaker for this luncheon meeting will be Professor James A. Reyniers. He is director of the Lobund Institute at the University of Notre Dame. His luncheon topic will be "Future Contribution of Germ Free Technique to Preventive Medicine".

The Luncheon will adjourn in time for those present to attend the General Assembly scheduled in the Ballroom for 1:30 p.m.

## PHI CHI FRATERNITY LUNCHEON

ROOM 107

Thursday noon, May 17, 1956

The Phi Chi Fraternity will have a luncheon meeting on Thursday noon, May 17, in Room 107 on the first floor of the Hotel Sherman.

Dr. Jacob E. Reisch of Springfield, Editor of the Phi Chi Bulletin, will be in charge of the plans.

All members of the fraternity are welcome to attend.

# General Assembly

THE BALLROOM

Thursday Afternoon, May 17, 1956

Presiding: Chauncey C. Maher, Chicago

Assisting: Jacques M. Smith, Chicago

1:30 "Germfree Research: A Basic Study in Host-Contaminant Relationship. The Germfree & Conventionally Contaminated Animal from Birth to Weaning."
PROFESSOR JAMES A. REYNIERS, South Bend, Indiana, Research Professor of Bacteriology, Lobound Institute, University of Notre Dame

1:50 "Unexpected Sudden Deaths"
JERRY J. KEARNS, Chicago, Associate Professor of Clinical Pathology, University of Illinois School of Medicine; Pathologist, St. Elizabeth's Hospital.

2:10 "Cholelithiasis"
CHARLES G. JOHNSTON, Detroit, Michigan, Professor and Chairman of Department of Surgery, Wayne University of Medicine

2:50 RECESS TO VIEW EXHIBITS

Presiding: James Herbert Mitchell, Chicago

Assisting: Milton M. Mosko, Chicago

3:10 "Sunlight and its Effect on the Skin"
JOHN H. LAMB, Oklahoma City, Oklahoma; Clinical Professor of Dermatology, University of Oklahoma School of Medicine

3:30 "Complications of Chronic Bronchial Asthma"
VINCENT DERBES, New Orleans, Louisiana, Professor of Medicine, Tulane University of Louisiana School of Medicine; Visiting Physician, Charity Hospital.

3:50 "The Present Status of the Salk Poliomyelitis Program"
EDWARD KRUMBIEGEL, Milwaukee, Wisconsin, Health Commissioner of Milwaukee; Professor and Chairman of the Department of Public Health and Preventive Medicine, Marquette University School of Medicine.

## LOYOLA UNIVERSITY ALUMNI DINNER

CRYSTAL ROOM

Thursday Evening, May 17, 1956

The Medical Alumni of Loyola University's Stritch School of Medicine will meet for their annual dinner during the convention of the Illinois State Medical Society, on Thursday evening, May 17, in the Crystal Room of the Hotel Sherman.

Dr. Maurice Hoeltgen of the class of 1932 is serving as chairman of the dinner.

Dinner will be served at 7:00 p.m., and the price is $6.50 per person.

## PHI BETA PI FRATERNITY SMOKER

The Theta Chapter, Phi Beta Pi Fraternity will have its annual Alumni Smoker on Thursady evening, May 17, from 7:30 to 9:00 p.m. The smoker will be held in the 8th floor lounge of Abbott Hall, 710 North Lake Shore Drive.

For transportation call Delaware 7-5700. For those who are driving their own cars, there is parking space available at Abbott Hall.

# Programs For Friday, May 18, 1956

## ILLINOIS ASSOCIATION OF BLOOD BANKS

**Sixth Annual Meeting**

LOUIS XVI ROOM

Friday afternoon, May 18, 1956

**SCIENTIFIC PROGRAM**

2:00 "Current Status of the Plasma Hepatitis Problem"
J. GARROTT ALLEN, University of Chicago, Chicago

2:15 Discussion

2:20 "Observance of the H.I.H. Minimum Requirements for Human Blood"
I. Survey by the Standards Committee of the Illinois Association of Blood Banks.
KURT STERN, Blood Center, Mount Sinai Medical Research Foundation and Hospital, Chicago

2:30 II. The Role of the Illinois Department of Public Health in This Survey
HERBERT E. McDANIELS, Ph.D., Chief, Bureau of Laboratory Evaluation, State Department of Public Health, Chicago.

2:40 Discussion

2:45 "Observations on the Prozone Phenomenon"
L. I. DAGOVITZ and C. A. SCHLUTZ, Michael Reese Research Foundation, Chicago.

3:00 Discussion

3:05 "Progress of the North Central District Clearing House"

PAUL A. VAN PERNIS, Medical Director, Northern Illinois Blood Bank, Rockford

3:20 PANEL DISCUSSION OF QUESTIONS SUBMITTED:

1. PAUL A. VAN PERNIS, MODERATOR
   Medical Director, Northern Illinois Blood Bank, Rockford
2. DONALD R. RUSS, University of Illinois College of Medicine, Chicago
3. KURT STERN, Blood Center, Mount Sinai Medical Research Foundation and Hospital, Chicago
4. DENNIS B. DORSEY, Pathologist, Lakeview Hospital, Danville
5. COYE C. MASON, Chicago

4:00 BUSINESS MEETING and adjournment.

## SECTION ON PATHOLOGY

Chairman ..... Jerry J. Kearns, Chicago
Secretary ..... Frederick Bauer, Chicago

CRYSTAL ROOM
Friday Morning, May 18, 1956

9:00 a.m. PANEL DISCUSSION: METHODS OF FORENSIC PATHOLOGY FOR THE GENERAL PATHOLOGIST

(A review of methods of collecting evidence, disposition of evidence and other examinations that may be available when pathologists are called for a medico-legal autopsy. The discussions are planned to be practical and helpful).

MODERATOR: JERRY J. KEARNS, Associate Professor of Clinical Pathology, University of Illinois; Director of Pathology Laboratory, St Elizabeth Hospital, Chicago

1. Identification of Individuals, Stains, and Weapons. Lie Detection. LIEUTENANT JOHN ASCHER, Chief, Crime Detection Laboratory Chicago Police Department
2. Identification of Bones. A. A. ZIMMERMANN, PH.D., Professor of Anatomy, The University of Illinois, College of Medicine, Chicago
3. Identification of Blood Stains. ISRAEL DAVIDSON, Professor and Chairman, Department of Pathology, Chicago Medical School; Director, Department of Pathology, Mt. Sinai Hospital, Chicago
4. Medico-Legal Autopsy. EDWIN F. HIRSCH, Director of Pathology, St. Luke's Hospital, Chicago
5. Toxicological Examinations. WALTER J. R. CAMP, M.D., and Ph.D., Professor of Pharmacology and Toxicology, University of Illinois, College of Medicine; Toxicologist for the Coroner of Cook County and State of Illinois, Chicago
6. Legal Evaluation of Evidence from an Attorney's Point of View. IRWIN D. BLOCH, First Assistant State's Attorney of Cook County, Chicago.

Luncheon and Business Meeting — Election of Section Officers.

## THE DISASTER COMMITTEE of the CHICAGO CHAPTER of the AMERICAN RED CROSS

Old Chicago Room No. 101
Friday Morning, May 18, 1956

"DISASTER PREPAREDNESS"

Dr. Michael Mason will give a brief explanation of the organization and functions of the Disaster Committee. A movie will be presented entitled "When Disaster Strikes". Dr. Sidney N. Lyttle will talk on "The Flint, Michigan Disaster".

Dr. Franklin Lounsbury of Chicago is in charge of the program, which will open at 9:00 a.m.

# Technical Exhibitors

Abbott Laboratories, J. W. Addington, North Chicago, Booth 51.

American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Booth 24.

Audio-Digest Foundation, J. M. Burke, 800 N. Glendale Ave., Glendale, Calif., Booth 22.

Baby Development Clinic, Mrs. Hermien Nusbaum, 600 S. Michigan Ave., Chicago, Booth 8

Baker Laboratories, Inc. F. G. Rice, 4614 Prospect Ave., Cleveland, Ohio, Booth 59.

Blue Cross-Blue Shield Plan, Ruth Brannon, 425 N. Michigan Ave., Chicago, Booth 42-43.

Chicago Pharmacal Co., A. B. Taylor, 5547 N. Ravenswood Ave., Chicago 40, Booth 13.

Chicago Reference Book Co., 185 N. Wabash Ave., Chicago, Booth 67.

Ciba Pharmaceutical Products, Inc., J. Brownlee, 556 Morris Ave., Summit, N. J., Booths 48-49.

Chicago Seven-Up Bottling Co., J. E. Kenney, 300 W. 83rd St., Chicago, Booth 1.

The Coca Cola Company, J. T. Beers, P. O. 1734, Atlanta 1, Georgia, Booth 11.

Daniels Surgical & Medical Supplies, D. F. Roback, 3144 N. Narragansett Ave., Chicago, Booths 15, 16, 17.

Dayless Mfg. Co., Leslie Hoffman, 3257 N. Western Ave., Chicago 18, Booth 28.

Doho Chemical Corp., H. R. Steinmann, 100 Varick St., New York 13, Booth 10.

Eisele & Company, Thos. Hopkinson, 109 Spring St., Nashville, Tenn., Booth 7.

Eli Lilly & Company, Wm. D. Crooks, Indianapolis 6, Indiana, Booths 56-57.

Encyclopaedia Britannica, Joseph A. Wittchen, 14 E. Jackson Blvd., Chicago, Booth 69.

E. Fougera & Co., Inc., R. J. Chase, 75 Varick St., New York, Booth 9.

Geigy Pharmaceuticals, D. M. Beverly, 220 Church St., New York 13, Booth 32.

Health Insurance Council, J. R. Williams, 208 S. LaSalle St., Chicago 4, Booths 38-29.

H. J. Heinz Company, F. B. Heard, P. O. Box 57, Pittsburgh 30, Penn., Booth 3.

Lederle Laboratories Div., American Cyanamid Co,. W. H. Buch, Pearl River, N. Y., Booth 66.

Liebel-Flarsheim Co., C. A. Branham, 111 E. Amity Road, Cincinnati 15, Ohio. Booth 50.

J. B. Lippincott Co., G. H. Turner, E. Washington Square, Philadelphia 5, Pa., Booth 52.

S. E. Massengill Co., M. J. Hardwick, 527 Fifth St., Bristol, Tenn., Booth 27.

Mead Johnson & Co., H. C. Hallum, Evansville 21, Indiana, Booth 62.

Medco Products Co. Inc., L. S. DeGroff, 3603 E. Admiral Place, Tulsa 12, Okla., Booth 45.

Medical Aids, Inc., S. V. Bentley, 204 N. Northwest Highway, Park Ridge, Ill., Booth 58.

Medical Protective Co., R. E. Wright, Fort Wayne, Indiana, Booth 63.

V. Mueller Company, Wm. Merz, 320 S. Honore St., Chicago, Booth 46.

The National Drug Co., J. T. Bollettieri, Philadelphia, Pa., Booth 25.

National Live Stock & Meat Board, C. F. Neumann, 407 S. Dearborn St., Chicago 5, Booth 53.

National Production Co., H. George, 4561 St. Jean Ave., Detroit 14, Mich., Booth 12.

Nepera Chemical Co. Inc., G. J. Rohrmann, Nepera Park, Yonkers, N. Y., Booth 36.

Northern Illinois Medical Service, K. K. Clark, 227 N. Wyman St., Rockford, Booth 37.

Parke, Davis & Co., J. A. MacCartney, Detroit 32, Michigan, Booth 60.

Parker Aleshire & Co., E. T. Luehr, 175 W. Jackson Blvd., Chicago 4, Booth 6.

Pfizer Laboratories, G. F. Penny, 630 Flushing Ave., Brookyln 6, N. Y., Booth 55.

Professional Management, Peoples Bank Bldg., Bloomington, Ill., Booth 33.

**PROFEXRAY, INCORPORATED**
**MAYWOOD**
**Booth 18**

Purdue Frederick Co., S. A. Lubman 135 Christopher St., New York 14, Booth 68.

R. J. Reynolds Tobacco Co., J. A. Vaughn, Winston-Salem, N. Carolina, Booth 14.

A. H. Robins Co., Edna M. Weems, 1407 Cummings Dr., Richmond 20, Va., Booth 2.

J. B. Roerig & Co., S. S. Sherman, 536 Lake Shore Drive, Chicago 11., Booth 31.

Sanborn Company, D. M. Beveridge, 122 S. Michigan Ave., Chicago 3, Booth 29.

Sandoz Pharmaceuticals, H. D. Davis, Route 10, Hanover, New Jersey, Booth 4.

W. B. Saunders Co., Anne Higgins, West Washington Square, Philadelphia 5, Pa., Booth 47.

Schering Corporation, Ralph Najarian, Bloomfield, New Jersey, Booth 64.

Julius Schmid, Inc., R. L. Waterfall, 423 West 55th St., New York 19, Booth 40.

G. D. Searle & Co., Bruce Beckman, P. O. Box 5110, Chicago 80, Ill., Booth 61.

Sharp & Dohme, D. M. Robertson, Philadelphia 1, Penna., Booth 54.

Sherman Laboratories, E. A. Lacey, 5031 Grandy Ave., Detroit 11, Michigan, Booth 26.

Smith, Kline & French Laboratories, T. L. Barsky, 1530 Spring Garden St., Philadelphia 1, Penna., Booth 19.

E. R. Squibb & Sons, Robt. Bessette, 745 Fifth Ave., New York, N. Y., Booth 21.

United States Tobacco Co., L. A. Bantle, 630 Fifth Ave., New York 20, Booth 35.

University of Chicago Press, Pat Daulton, 5750 Ellis Ave., Chicago 37, Booth 34.

The Upjohn Co., W. O. Miller, Kalamazoo 99, Michigan, Booth 65.

Vitamin Products Co., R. E. Grauel, 2023 W. Wisconsin Ave., Milwaukee 3, Wis., Booth 23.

Winthrop Laboratories Inc., J. J. Martocci, 1450 Broadway, New York 18, Booth 5.

The Zemmer Company, Wm. Addenbrook, 3943 Sennott St., Pittsburgh, Pa., Booth 30.

# Scientific Exhibits

Coye C. Mason, Director and Chairman..Chicago
Arkell M. Vaughn.....Chicago
Dwight E. Clark.....Chicago
Leo M. Zimmerman.....Chicago
L. W. Peterson.....Chicago
Harold L. Method.....Chicago
Everett P. Coleman.....Canton
J. C. Thomas Rogers .....Urbana

BOOTH No. 1

**Title: SURGICAL TREATMENT OF VARICOSE VEINS BY TWO-TEAM TECHNIQUE**

Exhibitor: Arkell M. Vaughn, Cornelius A. Annan, John A. Caserta

Institution: Department of Surgery, Stritch School of Medicine of Loyola University, Mercy Hospital and Vaughn Medical Group

Description: A large picture in the background shows the two-team technique. Drawings detail the anatomy and four charts show the anatomy and the surgical treatment of high ligation and stripping of the saphenous vein. Charts explain the evolution of the treatment of varicose veins and the test used before attempting surgical treatment of varicose veins. Charts show the contradindications for surgery and the strippers used in the operation.

BOOTH No. 2

**Title: ALTERATIONS IN THE CENTRAL NERVOUS SYSTEM ASSOCIATED WITH VARIOUS FUNGUS INFECTIONS**

Exhibitor: Louis D. Boshes

Institution: Division of Neurology and Psychiatry, Department of Medicine and Microbiology, Michael Reese Hospital. Department of Neurology and Psychiatry, Northwestern University Medical School

Description: In this exhibit are presented five cases of widespread invasion by fungus organisms. Included are three cases of torulosis, one of coccidioidomycosis and one of aspergillosis in which there was a joint infection with Candida Albicans which was a disseminated process involving many tissues and also producing multiple granulomatous abscesses throughout the brain. History, mycology treatment and pathology are discussed in short summaries and in more complete detail in separate booklets attached to the exhibit. In detail will be emphasized the approach at diagnosis from both the clinical and laboratory points of view. Management, including symptomatic and supportative care, the use of various antibiotics, corticotrophin therapy, 2-aminostilbamadine, and actidione are discussed fully. At the same time, the benefits and hazards of each of these agents will be evaluated. Finally that there may be relationship between the infection and these drugs during, or after these treatments, between the infection and these drugs during, or after these treatments, will be postulated.

BOOTH No. 3

**Title: A BETTER UNDERSTANDING OF ACID-BASE BALANCE**

Exhibitor: Harry F. Weisberg

Institution: Mt. Sinai Medical Research Foundation and the Chicago Medical School

Description: The terminology of acid-base balance and the Henderson Hasselbalch equation is confusing to most physicians. The exhibit will start with definitions of terms and using tables and diagrams, illustrating the mechanics of acid-base alterations utilizing the principles of a primary lever. The etiologies and mechanics of altered acid-base balance will be presented. A model will be available for the physician to be able to alter the bicarbonate and/or carbonic acid side of the balance, illustrating how the acidosis or alkalosis occurs and what steps are necessary for the body to compensate for pathological change.

BOOTH No. 4

**Title: SURGICAL COMPLICATIONS OF PREGNANCY**

Exhibitor: Frederick H. Falls and Miss Charlotte S. Holt

Institution: University of Illinois, College of Medicine, Chicago

Description: The exhibit consists of drawings, sculptures and lettered charts depicting various surgical conditions complicating pregnancy, some of which involve the genital tract but not as part of the pregnancy. These are grouped under five general headings:

1. Tumors
2. Circulatory
3. Gastro-intestinal
4. Renal-pulmonary
5. Miscellaneous

The problems presented to the obstetrician are primarily discussed rather than the surgical management of the complication.

BOOTH No. 5

**Title: INTESTINAL OBSTRUCTION IN THE NEWBORN**

Exhibitor: William Riker, Willis J. Potts, Arthur DeBoer, Thomas G. Baffes

Institution: Children's Memorial Hospital, Department of Surgery, Chicago

Description: Diagnosis and treatment of various forms of intestinal obstruction in the newborn.

BOOTH No. 6

**Title: LENTE INSULIN — USE IN CHILDREN**

Exhibitor: Robert M. Lussky, Alvah L. Newcomb, Matthew M. Steiner, Howard S. Traisman

Institution: Children's Memorial Hospital, and Evanston Hospital, and Northwestern University Medical School, Chicago

Description: Graphs illustrating composite blood glucose curves and individual glucose curves. Questions and answers regarding lente insulin.

BOOTH No. 7

**Title: CURRENT PRACTICAL GYNECOLOGY**

Exhibitor: Walter J. Reich, Mitchell J. Nechtow, Jerome Reich

Institution: Cook County Hospital, Cook County Graduate School of Medicine and the Chicago Medical School

Description: This exhibit deals with problems as they arise in everyday practice of gynecology — be then in general practice or in a specialty. The diagnosis, differential diagnosis and management of conditions in pediatrics, in adolescence or teen agers, in childbearing women, in geriatric patients and psychosomatic problems will be shown. The acute gynecological abdomen is discussed in differential diagnosis.

BOOTH No. 8

**Title: FLUID AND ELECTROLYTE BALANCE**

Exhibitor: James Graham

Institution: Springfield Rural Urban Clinic

Description: Basic principles of maintaining fluid and electrolyte balance are presented. When oral intake is impaired, food and water must be supplied parenterally. This means water, electrolytes, calories, proteins and vitamins. There are available so many combinations of electrolytes, nutrients and vitamins that one has little difficulty in compounding at the bedside a solution of proper proportions that will correct the abnormalities at hand. An understanding of the problems involved in fluid balance is essential to the intelligent use of available preparations.

BOOTH No. 9

**Title: MODERN MANAGEMENT OF THE CLEFT LIP AND CLEFT PALATE PATIENT**

Exhibitor: Walter W. Dalitsch

Institution: Northwestern University Cleft Palate Institute

Description: Transparencies in color with descriptive legends mounted in stainless metal case, depicting the modern management of cleft lip and cleft palate patients. The multi-phase problems of abnormal appearance, speech impairment, hearing defects. Orthodontic and dental disturbances are shown. Skilled specialists, in many fields, must work as a co-ordinated team to attain best results.

BOOTH No. 10

**Title: POTENTIALLY PATHOGENIC BACTERIA CARRIED IN THE RESPIRATORY TRACTS OF PHYSICIANS**

Exhibitor: Jerome J. Landy, Isabelle Havens, Ross S. Benham

Institution: University of Oklahoma, University of Chicago

Description: The exhibit will show by maps, table and photographs the epidemiology and antibiotic resistance patterns of Staph. aureus, enteric bacteria and other potential pathogens which have been found in the respiratory tracts of surgeons. Isolation, identification and sensitivity testing methods will be presented. The relationship between the carrier rate in surgeons and the rate of wound infections and that between carrier rate and patient contact will be shown.

BOOTH No. 11

**Title: CONTROLLED ARREST FOR CARDIAC SURGERY WITH HYPOTHERMIA**

Exhibitor: Peter V. Moulder, Richard G. Thompson, Robert W. Harrison, William Kiskind,

Barry Siegal, Curtis A. Smith and William E. Adams

Institution: University of Chicago, Department of Surgery

Description: Hypothermia protects the brain and other body organs from the effects of anoxia during the period of circulatory arrest required for intracardiac procedures. The heart has much less protection as it continues to work. Experimental studies on dogs are presented to demonstrate increased cardiac protection by acetylocholine inhibition with rapid, effective resuscitation being obtained with the use of intracoronary atropine. The use of this method to perform procedures in all four chambers of the heart and on the coronary arteries is demonstrated. Clinical cases are summarized.

BOOTH No. 12

**Title: THE SURGICAL TREATMENT OF GASTRIC AND DUODENAL ULCERS**

Exhibitor: Lester R. Dragstedt, Herzl Ragins, Clifton F. Mountain, Clarence M. Baugh, Jaime Barcena, Jose Bravo

Institution: University of Chicago, Department of Surgery

Description: Experimental and clinical evidence will be presented indicating that peptic ulcers are due to a hypersecretion of gastric juice rather than to a local decrease in resistance of the mucous membrane; further, that duodenal ulcers are usually due to a hypersecretion of gastric juice of nervous origin and gastric juice of humoral origin. Evidence will be presented indicating that a hypersecretion of gastric juice of humoral origin can be produced in experimental animals and that typical ulcers regularly result when this is done. Both clinical and experimental evidence will be presented indicating that stasis in the stomach, as a result of pyloric stenosis or gastric atony, are common factors which produce a phyersecretion of humoral origin in gastric ulcer patients.

BOOTH No. 13

**Title: THE USE OF MECHANICAL RESPIRATORS BY THE ANESTHETIST, SURGEON AND INTERNIST**

Exhibitor: E. Trier Morch, Edward E. Avery, Geraldine Light, John Cunningham

Institution: University of Chicago, Northwestern University Medical School

Description: Mechanical respirators will be demonstrated. The indications and use of the positive-negative phase respirator for controlled ventilations during anesthesia will be demonstrated. The intermittent positive pressure respirator has found wide clinical application by the surgeon and internist. The restoration of adequate ventilation is vital to survival whenever an insufficiency exists. The respirators use is illustrated for ventilatory insufficiency due to: central nervous system damage, (bulbar poliomyelitis, brain injuries, cerebral vascular accidents); pulmonary insufficiency (pre and post operative cases with advanced emphysema or pulmonary disease); and damage to peripheral respiratory mechanism (crushing injuries of chest wall, diaphragms, etc., myasthena gravis).

BOOTH No. 14

**Title: BETTER MEDICAL WRITING**

Exhibitor: Lee D. Van Antwerp, Harold Swanberg

Institution: American Medical Writers' Association, Quincy

Description: This exhibit consists of a series of panels outlining the aims, objects, organization and accomplishments of the American Medical Writers' Association.

BOOTH No. 15

**Title: MICROSCOPICALLY BENIGN BUT CLINICALLY MALIGNANT LESIONS OF THE HEAD AND NECK**

Exhibitor: Frederick J. Pollock, Paul B. Szanto

Institution: Illinois Eye and Ear Infirmary, Department of Public Welfare, State of Illinois

Description: There are a number of tumors observed by otolaryngologists which present a benign histological appearance. Due to their location in proximity to vital structures, tendency to local recurrent, vascularity, destructive character and other factors, the life of the patient is endangered, just as in histologically malignant tumors. Some representative cases such as nasopharyngeal fibroma, inverting papilloma, glomus jugulare are presented. These are illustrated by histories, clinical photographs, x-rays and photomicrographs, demonstrating the importance of careful study and evaluation of each individual case. Final decision is determined by the combined efforts of the pathologist and the clinician.

BOOTH No. 16

**Title: PALLIATION OF ESOPHAGEAL OBSTRUCTION DUE TO CARCINOMA WITH A PERMANENT INTRALUMINAL TUBE**

Exhibitor: S. A. Mackler, G. Bard

Institution: Cook County Hospital, Department of Thoracic Surgery; Michael Reese Hospital, Chicago Medical School

Description: Because of involvement of adjacent vital structures, resection of the esophagus for carcinoma is frequently impossible, even for the sole purpose of palliation of obstruction without the expectation of cure. A method is described whereby palliation of obstruction may be achieved by the introduction of a permanent indwelling tube. The tube is inserted at the time of thoracic exploration when it is determined that resection of the esophagus is not feasible.

BOOTH No. 17

**Title: CHLORPROMAZINE-RESERPINE CLINIC FOR MENTAL PATIENTS**

Exhibitor: Werner Tuteur
Institution: Elgin State Hospital, Elgin
Description: The Exhibit summarizes our experience with chlorpromazine, reserpine and a combination of both on the most regressed patients of Elgin State Hospital. Symptomatic improvement and dosage of chlorpromazine and reserpine will be indicated in tabulated form on several charts. Special attention will be given to the satisfactory discharge rate and length of discharge of these patients after improvement had been maintained. A balopticon will show colorslides demonstrating their activities at home and at places of employment after discharge.

BOOTH No. 18

**Title: STANDARD NOMENCLATURE — ORGANIZATION**

Exhibitor: Adaline C. Hayden
Institution: American Medical Association
Description: The exhibit explains how the various committees function when specific entities are presented to them for consideration and inclusion in the nomenclature. It further shows recommended installations.

BOOTH No. 19

**Title: AGING IS EVERYBODY'S BUSINESS**

Exhibitor: Leslie Freeman
Institution: Illinois Public Aid Commission
Description: A presentation on the problem of aging showing the increase in the aged population and a corresponding increase in the Nursing Home population. The exhibit points out the responsibility of the Illinois Public Aid Commission in maintaining a decent and healthful standard of living and providing personalized guidance and service, sponsorship of a state-wide advisory committee on Aging, and a program of rehabilitation for the aged.

BOOTH No. 20

**Title: ACTIVITIES IN THE ILLINOIS DEPARTMENT OF PUBLIC WELFARE**

Exhibitor: Otto L. Bettag
Institution: State of Illinois, Department of Public Welfare
Description: Booth depicting informational exhibit on mental health.

BOOTH No. 21

**Title: THE DOCTOR, THE VOCATIONAL REHABILITATION TEAM AND THE VOCATIONAL REHABILITATION CLIENT**

Exhibitor: E. C. Cline
Institution: Illinois Division of Vocational Rehabilitation
Description: Background exhibit board showing the role of the physician in the evaluation of a disabled person's potentialities by the rehabilitation team. The exhibit also includes a disabled person at work demonstrating the special skill he has as the result of vocational rehabilitation.

BOOTH No. 22

**Title: OPPORTUNITIES IN THE UNITED STATES PUBLIC HEALTH SERVICE**

Exhibitor: Harold M. Graning
Institution: Public Health Service, Department of Health, Education and Welfare
Description: The exhibit briefly describes the role of the service in the areas of Clinical Medicine, Research and Preventive Health Services. In the last panel it suggests that professional personnel may join the Service's Commissioned Corps either for careers in the Public Health Service or for professional service in national emergencies.

BOOTH No. 23

**Title: EASTER SEAL SERVICES FOR THE CRIPPLED IN ILLINOIS**

Exhibitor: Elizabeth Jameson
Institution: Illinois Association for the Crippled, Inc.
Description: Depicts programs of direct services carried on in Illinois for crippled children and adults.

BOOTH No. 24

**Title: A NEW METHOD OF PELVIC FIXATION**

Exhibitor: William Johnson
Institution: The Galesburg Clinic

# PROGRAM
# of the
# TWENTY-EIGHTH ANNUAL MEETING
# of the
# WOMAN'S AUXILIARY
# ILLINOIS STATE MEDICAL SOCIETY
# May 14, 15, 16, 17, 1956
## HOTEL SHERMAN Chicago

A most cordial invitation is extended to all members of the Woman's Auxiliary to the Illinois State Medical Society, and to the wives and guests of physicians attending the meeting of the Illinois State Medical Society, to participate in all social functions and attend the general sessions of the Auxiliary.

Headquarters will be at the Hotel Sherman. Tickets may be secured at the registration desk during the convention, or through your County, or by writing the ticket chairman, Mrs. J. L. Marks, 554 West 107th Street, Chicago, Illinois direct, in advance of the meeting.

Please register when you arrive and obtain your badge and program.

### PRE-CONVENTION SCHEDULE

Monday, May 14, 1956

3:00 p.m. to 5:00 p.m.
Registration, Hotel Sherman House on the Roof Solarium

1:30 p.m.
Pre-Convention Board Meeting, House on the Roof Solarium

### CONVENTION PROGRAM

Tuesday, May 15, 1956

8:30 a.m. to 4:00 p.m.
Registration, Lobby, Hotel Sherman

9:00 a.m.
Formal Opening of the Twenty-Eighth Annual Meeting of the Woman's Auxiliary to the Illinois State Medical Society.

FIRST SESSION—House of Delegates, The Assembly Room

Presiding Officer ..... Mrs. Warren Young, President
Invocation ..... Rev. Robert Dahl, Chaplain Wesley Memorial Hospital, Chicago
Pledge to the Flag .... Mrs. G. Henry Mundt
Auxiliary Pledge .... Mrs. James P. Simonds
Welcome ..... Mrs. Matthew Uznanski
Response ..... Mrs. N. D. Crawford
Introduction of Distinguished guests and Members ..... Mrs. Warren Young

BUSINESS SESSION

Credentials and Registration ..... Mrs. Fernly Johnson
Convention Rules of Order Mrs. Glenn Suthers
Adoption of Convention Program
Appointment of Reference Committees
Appointment of Reading Committees
Appointment of Committee on Courtesy and Resolutions
Coffee Break
President's Reports
Convention Announcements ..... Mrs. E. H. Leveroos

11:00 Adjournment

12:00 noon

LUNCHEON honoring Past Presidents
Introduction of Guest Speaker, Leo P. A. Sweeney, Chairman, Advisory Committee
Guest Speaker ..... The Hon. Everett M. Dirkson, United States Senator from Illinois
Luncheon Chairman ..... Mrs. Albert Kwedar Immediate Past President
Co-Chairman ..... Mrs. Henry F. Berchtold

REFERENCE COMMITTEE MEETINGS

General Reference Chairman . Mrs. Lee Hamm

3:00 p.m.
Reports of Officers and Directors, Room 106

3:30 p.m.
Reports of Standing Committees, Room 108

4:00 p.m.
Reports of Councilors, Room 111
Guests are welcome at all Reference Committee meetings

7:00 p.m.
BUFFET SUPPER
Chairman ..... Mrs. N. G. Chester
Co-Chairman ..... Mrs. Norman L. Sheehe
All Counties Participating.

Wednesday, May 16, 1956

8:30 a.m. to 4:00 p.m.
Registration, Lobby

9:00 a.m.
SECOND SESSION — House of Delegates .... House on the Roof
Presiding Officer ..... Mrs. Warren Young, President
Credentials and Registration ..... Mrs. Fernly Johnson
Introduction of Program ..... Mrs. Nicholas G. Chester

"LEADERSHIP CLINIC"
Presented by .... Dr. Martin P. Chworowsky

10:30 a.m. to 10:40 a.m.
Coffee break
"Leadership Clinic" — continued
Convention Announcements ..... Mrs. E. H. Leveroos

12:00 noon to 12:30 p.m.
Reference Committee Summaries .... House on the Roof

1:00 p.m.
Luncheon and Fashion Show ..... Wedgewood Room Marshall Field & Company
Luncheon Chairman ..... Mrs. J. S. Lundholm, Councilor First Councilor District

7:00 p.m.
ANNUAL DINNER honoring Dr. F. Garm Norbury, Retiring President Illinois State Medical Society
Guest Speaker ..... Dr. Elmer Hess, President, American Medical Association

Thursday, May 17, 1956

9:00 a.m.
THIRD SESSION — House of Delegates, Ballroom
Presiding Officer ..... Mrs. Warren Young, President
Credentials and Registration ..... Mrs. Fernly Johnson
Courtesy and Resolutions .. Mrs. E. M. Egan
Report of Nominating Committee ..... Mrs. Henry Christiansen
Election of Officers
Unfinished Business
New Business

11:30 a.m.
Memorial Service
Conducted by .... Mrs. Oliver E. Veneklasen
Organ music by Mr. Don De Vale

1:00 Luncheon ..... Assembly Room
Honoring Mrs. Warren Young, President and Mrs. Robert E. Dunlevy, President-Elect
Program by ..... ....Mrs. Lillian Brodahl Smith, Dramatist
Installation of Officers .. Mrs. Harlan English
Luncheon Chairman ..... Mrs. L. J. Houda
Co-Chairman ..... Mrs. Matthew Uznanski
Organ music ..... Mr. Don De Vale

3:30 p.m.
Post Convention Board Meeting, House on the Roof
Presiding Officer ... Mrs. Robert E. Dunlevy

***— and then there are the theatres, the shops, the new restaurants . . . .***

# MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

# Professional Liability

F. Lee Stone, M.D., Chicago

THE preamble of the "Principles of Medical Ethics" of the American Medical Association contains precepts which give us a working tool to follow.

Malpractice is an occupational hazard. We as physicians are subject to malpractice suits. The incidence of malpractice claims increased tenfold in one decade (the 1930's) and the situation continues to grow worse. So frequent are these claims today that, in some localities, any patient with less than perfect end results is a potential malpractice claimant.

One may well ask why it is that, despite the progress made, medical prestige is lower today than it was 25 years ago; why there has been a decrease in the confidence in which the profession was formerly held; why patients now so readily tend to express mistrust of their medical attendants to the point frequently of total collapse of confidence when an unhappy result occurs?

There is no simple answer to these questions. Nevertheless, there can be no doubt but that the ill will and misunderstanding engendered by the great number of malpractice cases have been important contributing factors. This is particularly unfortunate in that a majority of all current malpractice actions are not well founded, and because the danger of being sued is so great and so constant, the wise physician must now, even while caring for his patient, give thought to safeguarding himself, because an unjust malpractice action may result from the case.

*An address presented at a Postgraduate Conference in Effingham, March 7, 1956 arranged by the Post Graduate Committee of the Illinois State Medical Society.*

## OBLIGATION OF PHYSICIAN OR SURGEON TO PATIENT

The law does not hold the physician or surgeon liable for every untoward result which may occur in the treatment. It requires only that he have the learning and skill of physicians in good standing in the same locality, and that he use ordinary care and diligence in applying that learning and skill. Whether he has done so in a particular case is generally a matter for expert testimony to determine. Negligence will not be presumed; it must be proved affirmatively.

The relation existing between the physician or surgeon and the patient is of peculiar nature.

The law creates an implied contract, founded upon the duty the law imposes upon the physician in the interest of the public, which requires that he shall use ordinary skill and knowledge in any case. There is no implied contract that the physician will effect a cure.

Physicians are not liable at common law for refusing to attend a sick person who demands his services.

He is under no obligation to respond because he holds a state license to practice medicine.

When he accepts a person as a patient, then

his duties and corresponding obligations arise.

The rule in relation to learning and skill does not require the surgeon to possess that extraordinary learning and skill which belong to only a few men of rare endowments, but such as are possessed by the average member of the medical profession in good standing. Still he is bound to keep abreast of the times, and a departure from the approved methods in general use, if it injures the patient, will render him liable, however good his instructions may have been.

Laymen are familiar with the fact that the great majority of contracts between physician and patient are implied contract. *"Implied"* means the physician will treat the patient, and the patient will pay for the services when properly performed.

Duty as to frequency of visits is to be determined by the physician. This lasts until put to an end by assent of the parties.

A physician who leaves a patient at a critical stage of the disease without reason or sufficient notice to enable the patient to procure another medical attendant is guilty of a culpable dereliction of duty.

Where Christian Science treatment is prohibited by law, of course, a scientist cannot recover for his services. Where treatment is not so prohibited, he is entitled to his fee for such services.

There is nothing unmoral or unlawful in a contract between a Christian Science healer and one who desires to be treated. Its wisdom or folly is immaterial, and is for the parties and not the courts.

## LIABILITY FOR FAILURE TO SECURE CONSENT TO PERFORM AUTOPSY

The early English laws say the body belongs to the Church.

Now all courts concur in the holding that the right of possession of the dead body for the purpose of decent burial belongs to those most intimately and closely connected with the deceased by domestic ties, and that this right is one which the law will recognize and protect, such as husband, wife or next of kin.

Dr. Samuel A. Levinson of Chicago had a very enlightening article in the December 31 issue of the Journal of the American Medical Association. This article expressed the need for teaching legal medicine in the undergraduate school.

. . . "Every medical student and physician should receive information in (a) what constitutes a coroner's or medical examiner's case and the manner for investigating the cause of death; (b) forensic pathology and the study of unexpected death and the problems encountered in the similarity and differentiation of traumatic and homicidal deaths; (c) forensic toxicology and the pathological changes that may result; (d) forensic immunology and the application of blood groups and serology in the detection of crime; (e) the application of forensic psychiatry in medical and legal practices; (f) demonstrations by law-enforcing bodies in the techniques used in crime detection and deception; (g) the importance of medical records in courts; and (h) the doctor as a medical expert witness.

"All of these are basic materials of general interest and importance to every physician. Let us not overlook the fact that every patient under study by a physician in his office or hospital may be a potential medicolegal problem. Any accident, industrial or otherwise, or inhalation of noxious agents, may result in immediate or delayed injury resulting in inability to continue to work, or death. The physician in attendance in this instance can supply valuable information in the interest of public safety and justice. Any and all cases of accident, homicide, suicide, or attempted suicide first seen by the physician require not only knowledge in medical management but also his interpretation of the findings and his assistance in the administration of justice.

"There are many examples one can cite to illustrate further the reasons why the medical student and physician should have this type of knowledge. Sudden and unexpected deaths present a challenge to every physician. What are the underlying anatomic changes that bring this about? Anesthetics and mismatched blood given in transfusions cause reactions; a patient in the hospital who is permitted to go to the bathroom suddenly collapses and dies; infants and children are found dead in their cribs; someone who receives a superficial bruise or who has eaten food that he claims gave him heartburn dies suddenly. The lay person is unable to comprehend these unexpected and sudden

changes that affect members of their families, and quite often the physician is bewildered and can offer no explanation. I recall an episode where a patient was hospitalized because of anginal pains. According to the attending physician, the patient was progressing well, and he assured the patient and the family that within a few days the patient could go home. Then one day the patient experienced sharp substernal pain, developed a shock syndrome, and within fifteen minutes died. The attending physician was in a predicament to explain to the family the sudden and unexpected death of the patient. The doctor did not know what had taken place; he was accused of negligence in the management of the patient and was threatened with a court suit for malpractice. Fortunately, an autopsy was permitted, and it revealed a spontaneous rupture of the heart and hemopericardium. The attending physician now had the information, from the autopsy findings, to interpret to the patient's relatives the cause for the sudden and unexpected death. Also these findings prevented the alleged malpractice suit."



# H. R. 7225

**John A. Mirt**

AS this is being written, it appears that H.R. 7225, an amendment to the Social Security Act, may be subjected to a heated fight on the floor of the Senate. This may call for concerted action by the medical profession, letting Senators know where physicians stand on the question. Therefore, it is important that doctors are made aware of the effects of certain provisions of this measure.

The Senate Finance Committee held a lengthy hearing on the bill. The medical profession was given full opportunity to present its reasons for opposing the section providing for cash payments to totally disabled persons 50 years or older and that lowering the pensioning age for women.

A long list of doctors appeared before the committee and suggested that the economic impact of the proposal be studied before enactment into law. In this, the medical profession was backed by other groups — professional, business, educational.

The soundness of the arguments advanced undoubtedly was influential in the stand taken by the administration in the closing presentation. HEW Secretary Folsom, the final witness to appear before the committee, joined medicine in opposing the disability and age-lowering provisions.

*Department of Public Relations, Illinois State Medical Society*

Secretary Folsom warned of the "grave uncertainties involved and the potential heavy costs to all social security taxpayers." He added: "The committee is faced with a proposal for legislation in a delicate area of human motivation. It is impossible to proceed with the same degree of assurance that has accompanied other steps in the expansion of the social security system.

"Few subjects in the field of social security have been so controversial over the years and are so controversial today as the proposal for cash disability benefits. In the past, a wide area of agreement usually has developed before major changes were enacted in a program involving so many people and so many billions of dollars.

"There is no such agreement today. There is a great divergence of opinion on the difficulties of administering a cash disability program, our ability to control the costs and the effects on vocational rehabilitation."

Some of the points he made included:

(1) There should be no further tax burden in view of recent increases and the scheduled increase in social security taxes in 1960.

(2) The committee should give considerable weight to the testimony of medical witnesses regarding the great problems which they foresee in evaluating physical and mental conditions under the disability program.

(3) The lowering of the disability age to 50 would likely be the first step in coverage for workers at any age, adding almost $1.5 billions annually to the tax burden by 1980.

(4) The most important factor in rehabilitation is an incentive on the part of the individual to become self-supporting.

This position of the administration by no means eliminates the inherent dangers of H.R. 7225. It will be recalled that the measure passed through the House of Representatives in blitz fashion at the last session and with virtually no opposition.

Only sane leadership in the Senate prevented similar action in the upper house because labor has come out wholeheartedly for the measure and the Democrats plan to capture that vote by working for the passage of the bill. Even if the bill should be side-tracked, the record shows that the socialized medicine measures do not fade away — they reappear in a new form. They are like Hydra, the nine-headed serpent of Grecian mythology, only in a modern setting.

Thus, it is well to bear in mind the objections of the medical profession to certain provisions of H.R. 7225. Physicians may be called upon to marshal their forces at any time.

There are two particularly dangerous features in the bill as it passed the House. One concerns cash payments at the age of 50 for those certified as totally and permanently disabled. The other is the provision which would lower the pensioning age of women from 65 to 62.

There is no hard and fast rule for the determination of the total disability of a man, woman or child. Medical progress in recent years has helped to rehabilitate hundreds of thousands of people who had been considered hopeless cases. This advance in the treatment of the chronically ill will continue.

The medical problem in the determination of total disability is particularly difficult. This is more so when neurological and psychiatric factors are involved. Who can say that a person is incurable under such circumstances?

Abuses beyond comprehension could develop. In no time, the precinct captain would be a power in arriving at a diagnosis of disability.

A worse danger is the setback which will be given rehabilitation. The will to get well is an important adjunct in the treatment of the chronically ill. A person who has no such desire is a hopeless case.

The assurance of a steady pension, particularly to marginal income workers, will rob them of any wish to get well. There is no longer an incentive to become self-supporting. They have little to gain. It is human nature to take the easiest path if rewards are not commensurate with the efforts made.

Dr. Howard A. Rusk, one of the most outstanding authorities on rehabilitation, told the Senate Finance Committee that it has been estimated by experts that 97 per cent of all handicapped persons can be rehabilitated to the extent of gainful employment.

Thus, only about 3 per cent of the presently handicapped need to be taken care of. This can be done easily within our present framework of medical care.

There also is a psychological danger in branding a person "totally and permanently disabled." In many instances, a patient has hopes of some recovery. To pull the carpet out from under him, as it were, can easily have a disastrous emotional effect.

Would-be socializers of medicine found out that they cannot throw this country into an unsound medical program in one move. So, they have adopted a new tactic. They are seeking to gain their objective piecemeal. The 50-year figure for the pensioning of the totally disabled is merely a step to further amendments which in time would cover every disabled person.

Even before the Senate Finance Committee had concluded its hearing that proposal was suggested by Senator George (D., Ga.). Secretary Folsom recognized this threat and pointed out the danger in his testimony before the committee.

The cost of this grandiose scheme would be staggering. Robert J. Myers, chief actuary of the Social Security Administration, in analyzing the potential tax load for the benefit of the committee, estimated that the proposed benefits to the totally disabled 50 and over would cost about $900 millions annually. Later, unofficially, it was estimated that Senator George's amendment would double the cost.

Mr. Myers also said that H. R. 7225, if adopted in its original form with its other provisions, would mean an annual cost of $2.2 bil-

lions 25 years from now. This figure was based on the assumption that the administration of disability benefits would be strict and tight and that there would be high employment conditions.

Suppose we do grant the possibility of high employment conditions. But, can we hope that an administration of disability benefits would be strict and tight? That is too much to expect.

Mr. Myers in his testimony added: "If either of these assumptions did not materialize, the cost would be considerably higher. This has been the experience both in foreign systems and in private pension and insurance plans in this country."

You can rest assured there will be no exception. Thus the plan can only mean catastrophe. Insurance company leaders have testified that the Social Security program already is actuarially unsound. It has been estimated that the Social Security trust fund should amount to $35 billion in order to be able to guarantee the established benefits. Actually, it is about $14 billion short of that figure.

Nothing has been set aside for future Social Security liabilities. Any further promises of benefits will only increase the fund's liability to an estimated $300 billion. There are only two ways in which this can be met. One is through taxation. The other is through printing press money. Either is disastrous.

H. R. 7225 also proposes that the retirement age of women be reduced to 62. Once this level is attained, the next move would be for a further reduction. An earlier pension for men would most likely follow.

That is within the realm of possibility because we are in a stage of thinking that people should do as little work as possible. It was not so long ago that a 48-hour week was considered a proper use of labor. Today, 35 to 40 hours is set as the maximum.

Although the administration has been convinced that there are inherent dangers in H. R. 7225 which should be eliminated, this situation should not cause the medical profession to sit back nonchalantly. The battle has not been won by any means. Socializers never give up. They merely abide their time and strike when least expected. Or, this may come before the bill is put to a vote.

Only by the concerted action of physicians will the public be assured of a continuation of the high grade medical care which is unobtainable in any other part of the world.

Be ready to act — and to act fast — when called upon to do so.

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## More penicillin

A single allergic reaction to penicillin of the common delayed urticarial or serum sickness-like type does not necessarily preclude the possibility of subsequent treatment with penicillin. Most such patients do not develop persistent penicillin allergy and many accept penicillin at a later date without the slightest hint of difficulty. It is true that with evidence of an increasing anaphylactic hazard and with more patients exposed to more courses of penicillin, the physician quite properly uses other chemotherapeutic agents where possible for patients with such a past history. Nevertheless, it is well for him to know that in situations where the indication for the antibiotic is urgent, with suitable precautions he can attempt to reinstate therapy and, more often than not, may do so successfully. *Sheppard Siegal, M.D. Allergic Reactions to Antibiotics. New York J. Med. Aug.* 15, 1955.

# THE P. R. PAGE



## New Director of Public Relations

*Mr. Edward A. Uzemack, a Chicago newspaperman for 14 years, before entering public relations work, joined the staff of the Illinois State Medical Society as Public Relations Director and Assistant Secretary on April 1. For the past three years he was executive assistant in the Public Relations Department of the American Medical Association, assigned specifically as a traveling aide to the presidents of the A.M.A.*

*As an introduction to his new office, Mr. Uzemack delivered the following address on "Public Relations By County Medical Societies" at the annual Secretaries Conference in Springfield on March 24:*

During the past three years, I have had a rare opportunity to observe the operations of state and county medical societies throughout the United States. The county meetings ranged from sessions of the approximately 7,000-member Los Angeles County Medical Association to the eight-member Watonga County Medical Society in Oklahoma. Although my exposure to grassroots medical organization can only be regarded in the once-over-lightly category, I was impressed by the fact that from the largest to the smallest, all of these societies had some sort of public relations program in the works, even though they might not have spelled it out as such. As a matter of fact, the most recent survey of county medical society activities by the A.M.A.'s Council on Medical Service showed that of the 1,225 societies which co-operated in the study, 764 had a public relations committee.

A breakdown of this section of the survey revealed that public relations was the committee activity most frequently engaged in by societies with less than 100 members. I have heard and read dozens of attempts to define public relations but in my opinion it boils down to this:

Public relations is a deliberate effort to do the most good for the greatest number of people.

A public relations *program* is the vehicle which you build to carry to those you serve the story of your good intentions and your actual accomplishments. It also established the guideposts for the performance road which you must follow. There's no point in kidding ourselves — the establishment of a good relationship with the public requires that intentions be supported by deeds. If a county society announces publicly that it has set up a 'round-the-clock emergency call service, then that society should be prepared to provide a physician on very short notice 24-hours a day, seven days a week and 365 days a year. If such performance cannot be assured, then it would be better not to announce a formal emergency call service, for the public is quick to cry "fake!"

The number of emergency call systems has grown from 60 in 1948, when the AMA first published a report on such projects, to more than 710 in 1955.

Like the emergency call systems, county society grievance committees also serve as useful

public relations devices when they function objectively and the public is made aware of their existence. The AMA has just published a booklet of guides for grievance committees which was prepared by a special temporary committee of the Board of Trustees. One of our own Illinois physicians, Dr. Keith Frankhauser of Avon, is a member of this committee.

There are 704 societies with grievance committees now in operation. Of special significance is the fact that 225 of these committees were organized since 1953, indicating a growing awareness of their importance. Nearly half of the grievance committees — 301 to be exact — exist in county societies with less than 50 members.

Emergency call systems and grievance committees, are two examples of some of the more tangible public relations efforts which county medical societies can undertake with comparative ease and economy.

The recent public opinion survey conducted by an independent Chicago firm for the AMA disclosed that Americans have a good opinion of doctors generally, but that this opinion was based mostly on their contact with their own personal physicians. In speaking of physicians whom they did not know personally, they were inclined to be less charitable in their views. Most of the complaints involved fees, coldness on the part of the physician, impatience, lack of frankness, unavailability and incompetence. Now there's a public relations job made to order for every member of every county society not only in Illinois, but throughout the United States! What are we going to do about it?

Can we afford to permit this split opinion of the profession to exist indefinitely? Hardly — every doctor must realize that while his own patients may regard him as a great healer and humanitarian, in the eyes of his colleagues' patients he may appear to be something less than the ideal practitioner. If he is willing to accept this premise, then it is up to him to help convince the public that there is good in the medical profession as a whole. Since a strong county medical society is essential to a positive public relations program, he can start by joining his fellows in setting aside personal differences for the common good. Inadequacies in medical service can and should be stamped out in the seedling stage by an alert county society membership. And the county society should be on the lookout for opportunities to assume leadership in solving medical care problems which may arise in the community.

Recently I attended a meeting in a small city where a civic group was about to make hay out of a report that was highly critical of the emergency medical care service in that community. Although officials of the local medical society came to the meeting with enough evidence to deflate many of the criticisms, they were not content to just make a defense. Instead, they offered to lead in the formation of a city-wide commission which will study the problems that do exist and then move to solve them. Pledges of co-operation were given almost immediately and their proposal was acclaimed in the local press. Good public relations? . . . You're darned tootin'.

There are many ways in which public acceptance of organized medicine's objectives can be obtained. However, I think that we may have neglected one important area, and that is the role of the county medical society as the main source of medical information for the general public. In most instances, the county society has rightfully functioned as a service convenience for the local physicians. I've often wondered if it wouldn't be practical for the county societies to invite the public to make greater use of their facilities in seeking the right answers on matters pertaining to the medical profession? As it stands now, most of the information obtained by the public comes from uninformed sources.

I am proud of the fact that you have permitted me to come to work for you. During the next few months I will try to learn as much as I can about the county medical societies that comprise the Illinois State Medical Society so that I may be able to serve you most effectively. Dr. Harold Camp has promised to take me around the state for some person-to-person chats in your respective bailiwicks and I am looking forward to those visits. In the meantime, I shall be headquartered in the Chicago office of your state society, at 185 N. Wabash Avenue, where I hope you will write me or call me if you feel I can help you with any phase of your public relations planning. Prompt replies are guaranteed!

Since I have never attained the status of genius, I would appreciate very much any suggestions you may have on how the Public Relations Office can best help you. It is my ambition to make the office an active information center and a clearing house for public relations ideas. Please let me know what you want and I'll do my darndest to fill the order.

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## Tension headache

Of the 96 patients with psychogenic tension headache studied at the Mount Sinai Hospital Consultation Service, it was possible to demonstrate in 89 that problems of anger and aggression precipitated the headache. It is noteworthy that the average patient had no initial awareness that anger played any role in the genesis of his symptoms. This was particularly interesting to the physician who often saw a tirelessly repetitive pattern of headache following a situation that would stimulate anger or rage. A possible explanation may be that headache, among other functions, serves as a means of enabling the individual to remain unaware of the extent and violence of his rage. In the developmental history of individuals in our culture the full expression of anger and rage is checked at a very early age. It becomes intimately associated with prohibition and anxiety-laden fantasies of retribution. Thus, a situation stimulating anger which may become overwhelming presents a threat to the individual and necessitates some defense against this anger. The first line of psychologic defense may be repression—that is to say, actively remaining unaware of the emotion. However, remaining consciously unaware of an emotion does not eliminate the dynamics of that emotion or its somatic concomitants. Repressed or suppressed anger may precipitate the same physiologic reflex patterns as consciously felt emotion. Moreover, the very fact that the individual is unaware of an emotion prevents its adequate discharge. In fact, this unawareness often insures the chronic persistence of the emotion and its physiologic pattern to the point where somatic symptoms result. *Mortimer F. Shapiro, M.D. The Problem of Psychogenic Tension Headache. New York J. Med. Aug.* 15, 1955.

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## Nutrition in pregnancy

There would seem to be some rather impressive evidence in regard to the consequences of drastic limitation of caloric intake during pregnancy. Studies in Chicago have shown that when the energy requirements of the pregnant woman are not met, storage of nitrogen in the form of protein does not proceed at a satisfactory rate. Other studies indicate that women who are underweight at the beginning of pregnancy and who fail to come within a normal range during the first two trimesters have a higher than average proportion of premature infants. Nevertheless, I have been told of a teaching hospital that has only recently abandoned the routine prescription of a 1,000 calorie diet for prenatal clinic patients. The woman who is given such slim rations is sometimes told that it is important to control the size of the fetus. Yet there is impressive evidence that a diet so restricted as to affect the weight of the infant is pretty sure to take its toll on the mother. Periods of famine do result in lower birth weights. They also are likely to impair the health of child-bearing women. *Majorie M. Heseltine, Unfinished Business in Maternal and Child Nutrition. Pub. Health Rep. Feb.* 1956.

# CORRESPONDENCE



## Meeting of The Endocrine Society

Saturday, June 9, 1956

VIII. 2:00 p.m. CLINICAL SESSION

Chairmen: J. E. Howard, M.D. and E. P. McCullagh, M.D.

I. Symposium on adrenal function, especially as related to Cushing's syndrome.
   A. Assay of urinary and blood steroids and responses to ACTH. Claude J. Migeon, M.D. (Johns Hopkins Hospital)
   B. Clinical manifestations of Cushing's syndrome, its diagnosis and therapy. Randall G. Sprague, M.D. (The Mayo Clinic)

II. Diagnosis and treatment of diabetes insipidus. William C. Thomas, Jr., M.D. (Johns Hopkins Hospital)

*INTERMISSION*

III. Current laboratory methods used in evaluation of thyroid function, with special emphasis on errors in their interpretation. E. P. McCullagh, M.D. (Cleveland Clinic).

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## Illinois Society of Obstetrics and Gynecology

The Illinois Society of Obstetrics and Gynecology will have its annual meeting on Monday, May 14, at the Hotel Sherman. All physicians interested in attending will be most welcome.

Dr. Mary Louise Newman of Jacksonville, program chairman, has announced the following speakers and subjects:

"Recent Trends in Cesarean Sections"

J. H. RANDALL, Professor and Head of the Department of Obstetrics and Gynecology, University of Iowa Medical School, Iowa City.

"Diseases of the Adrenal Glands in Their Relation to Obstetrics and Gynecology"

Dr. BRADBURY (Ph.D.) of the Department of Obstetrics and Gynecology, University of Iowa Medical School, Iowa City.

"Blood Loss in Obstetrics"

WILLARD C. SCRIVNER, East St. Louis.

Dr. Worling Young of Geneseo is the President of the Illinois Society of Obstetrics and Gynecology this year, and Dr. Carl Greenstein of Champaign is President-Elect.

The meeting will be held in one of the private dining rooms on the first floor of the Hotel Sherman, the number of which will be posted on the bulletin board in the lobby.

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## Annual meeting Illinois Society of Anesthesiologists

May 13, 1956 — Hotel Sherman

The Illinois Society of Anesthesiologists will hold its annual meeting at the Hotel Sherman just prior to the opening of the annual meeting of the Illinois State Medical Society, scheduled for May 15-18.

The program which has been developed for

Sunday, May 13 is as follows:

9:00 a.m. Registration

10:00 to 12:15 SCIENTIFIC PROGRAM

"Office Anesthesia"

HUGH O. BROWN, St. Lake City, Utah
President, Utah Society of Anesthesiologists.

"Management of Anesthesia in Patients with Pulmonary Emphysema"

KARL L. SIEBECKER, Madison, Wisconsin.
Assistant Professor of Anesthesiology, University of Wisconsin Medical School.

"Fundamental Pharmacology in Relation to Anesthesia"

JOHN ADRIANI, New Orleans, Louisiana,
Director, Department of Anesthesia, Charity Hospital.

"Post-Operative Vomiting, Fact and Fancy"

EDWARD MAYER, Evanston, Illinois,
St. Francis Hospital.

12:30-1:45 ROUND TABLE LUNCHEON

2:00 p.m. "Cardiac Resuscitation: Panic or Purpose"

HARVEY C. SLOCUM, Colonel, USA MC, Washington, D.C.
Consultant in Anesthesiology, Department of the Army, Office of the Surgeon General.

Business Meeting and Election of Officers to follow the scientific program.

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## International Congress on Diseases of the Chest

The Fourth International Congress on Diseases of the Chest of the American College of Chest Physicians will be held in Cologne, Germany, from August 19 to August 23, 1956 under the patronage of the Federal Chancellor Dr. Konrad Adenauer. The first Congress after the war was held in Rome in 1950, the next one in Rio de Janeiro in 1952 and the third one in Barcelona in 1954. Eighty-six countries will send their representatives.

Prof. Dr. med. Dr.h.c. Gerhard Domagk will be the President, Prof. Dr. med. Dr.h.c. H.W. Knipping the Vice-President, Prof. Dr. med. J. Jacobi the General Secretary and Prof. Dr. med. J. Hein the Chairman of the Executive-Committee of the Fourth International Congress.

The main subjects which will be discussed at the Congress, deal with the problems of coronary diseases (diagnosis, pathophysiology and surgery), industrial diseases of the chest, tuberculosis, lung and heart function and tumors of the mediastinum. Several outstanding foreign and German scientists and clinicians will present papers on these subjects. This year's Congress will be held with special reference to surgery of coronary diseases. But presentations on any other subject in the field of diseases of the chest will also be accepted. The presentations will be followed by free discussions. The official languages for the Congress are: English, French, Spanish and German.

For more detailed information and inscription, please write to the secretariat of the Congress: Fourth International Congress of the American College of Chest Physicians, Koln-Deutz, Germany, Messeplatz.

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## Clinics for crippled children listed for June

Sixteen clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois Division of Services for Crippled Children. The Division will count 10 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing service. There will be 3 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The June Clinics are:

June 6 - Hinsdale, Hinsdale Sanitarium

June 6 - Rock Island Cerebral Palsy, Foss Home - 3808 8th Avenue

June 8 - Chicago Heights Cardiac, St James Hospital

June 12 - E. St. Louis, Christian Welfare Hospital

June 12 - Peoria, Children's Hospital

pital of DuPage County

June 14 - Elmhurst Cardiac, Memorial Hos-

June 14 - Springfield, St. John's Hospital

June 20 - Chicago Heights General, St. James Hospital

June 20 - Salem, Masonic Temple

June 21 - Rockford, St. Anthony's Hospital

June 22 - Chicago Heights Cardiac, St. James Hospital

June 26 - Effingham (Rheumatic Fever), St. Anthony's Hospital

June 26 - Peoria, Children's Hospital

June 27 - Elgin, Sherman Hospital

June 27 - Springfield (Cerebral Palsy), Memorial Hospital

June 28 - Bloomington A.M. (General), P.M. (Cerebral Palsy), St. Joseph's Hospital

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## State medical secretaries and assistants to organize

A meeting to organize an Illinois State Medical Secretaries and Assistants Association has been called for at the Leland Hotel, Springfield, Ill., Sunday, June 3, beginning at 10:30 a.m. The proposed association would become the Illinois State organization of the National Medical Secretaries and Assistants Association which will complete its organization at Milwaukee next October. The field and purpose is expressed in the following from the suggested constitution of the new association:

The association is a non-profit, educational organization whose objects are: (a) to bring into one association all medical secretaries and assistants organizations in the State of Illinois; (b) to provide an organization for those residing in Illinois counties where no medical secretaries or assistants societies are organized; (c) to appeal to women who are employed in the offices of (1) members of the Illinois State Medical Society; (2) Illinois hospitals and related institutions accredited by the American Medical Association; and (3) Illinois, city, county, state, or federal health boards or allied departments; (d) to maintain and advance high standards of professional employment and thereby render honest, loyal, and efficient service to the medical and allied professions and the public; (e) to meet from time to time to secure interchange of views of the members so that they may maintain such intelligent unity and harmony in every phase of their labor as will make effective the opinions of the medical and allied professions in their respective communities in relationship to the public welfare.

All Illinois women interested in the proposed association, regardless if whether or not there is a local organization of this type in their vicinity, should promptly communicate with Miss Dorothy Hoffstadt, 1101 Maine St., Quincy, Ill. The Swanberg Medical Foundation (Quincy Ill.) of the Adams County Medical Society, Ill., is assisting in the organization of the new association which is being sponsored by the Adams County Medical Secretaries and Assistants Club.

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## University of Illinois medical alumni meeting

The Medical Alumni Association, University of Illinois, College of Medicine will hold its Annual Banquet on Monday, May 14, 1956 in the Walnut Room at the Bismark Hotel, Randolph and Wells streets, Chicago, Illinois. It is informal. Guests are invited. Cocktails will be served at 6:00 P.M. and dinner at 7:00 P.M. The cost per plate is $7.50.

Reunions will be held for the classes of 1901, 1906, 1911, 1916, 1921, 1926, 1931, 1936, 1941 and 1946.

Please mail your check for reservations as soon as possible to Mrs. Michard H. Streicher, Honorary Executive Secretary, Medical Alumni Association, 415 Fullerton Pkwy., Chicago 14, Illinois.

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## Northwestern University Alumni Association

The Northwestern University Medical Annual Faculty-Alumni Reunion dinner will be held Saturday evening, May 12, at the Furniture Club of America, 666 Lake Shore Drive, Chicago. Couples are invited to attend.

The social period begins at 6:00 o'clock, and dinner will be served at 7:00 p.m. The traditional musical entertainment will be presented by the medical students, entitled, "Quo Vadis Medicus? '56. Operation Osculation".

Tickets for the dinner are $8.00 each and may be obtained at the Medical Alumni Office, 303 East Chicago Avenue, Chicago 11, before May 9.

Special tables will be reserved for the reunion classes: 1901, 1906, 1911, 1916, 1921, 1926, 1931, 1936, 1941, 1946 and 1951.

# AT THE EDITOR'S DESK



The medical profession has been trying to suppress publicity on the new oral antidiabetic sulfonamides. This is understandable because many products of this nature have appeared in the past and failed to live up to expectations. On the other hand, these new compounds (BZ55 and U2043, or Orinase®) are more promising. They have no effect in younger patients with severe diabetes but lower the blood sugar level in mild and elderly diabetics. It will not be easy to keep the research on these substances quiet and the appearance of news releases already indicate that the manufacturers are not interested in doing so.

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Seventeen cases of pneumonia were treated successfully with Tetracycline Hydrochloride; 12 had nonbacterial pneumonia. The patients were hospitalized for an average of 6.81 days and there were no complications or recurrences. But two to three weeks often elapsed before roentgenologic improvement took place.

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A new antituberculosis drug was described in an Upjohn abstract. The daily administration of oral Hinconstarch® was given to 12 patients with moderately to far advanced pulmonary tuberculosis for three months. According to the abstract, "The therapeutic effect was at least comparable with that of the best chemotherapeutic agents in present use."

‹ ›

The Purdue Frederick Company announces an aid for the more than eight million peptic ulcer sufferers in the United States. It is Sippylex,® an easy-to-take, multi-action preparation combining nonfat milk, vitamins, and an antacid.

‹ ›

Did you know that 80 million babies come into the world each year and that more than 75 per cent are delivered by a vast army of untrained attendants? Many are illiterate and ignorant of the simple rudiments of clean and safe maternity care. According to Briefs, the neonatal mortality from tetanus neonatorum has ranged as high as 50 per cent in certain localities of North China. The cause is obvious. Ancient custom and forklore demand that the native midwife dress the cord with mud.

‹ ›

One out of eight persons will go to a hospital this year; one out of every 60 of the nation's workers is employed in a hospital; and the bed count of all the hospitals in the country is more than 1,500,000. These statistics were supplied for National Hospital Week, May 16-20.

‹ ›

Dr. Leonard A. Scheele, head of the U.S. Public Health Service, says that the cancer cure rate has tripled in the past decade (from 15 to 50 per cent).

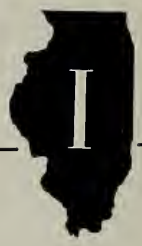
‹ ›

A British Medical Journal item states that straight whiskey, gin, and fortified wines may lead to hemorrhage or ulcer, especially if the drinks are large and are taken on an empty stomach.

‹ ›

Metropolitan Life reports that the average length of life of our wage earners and their families has reached the Biblical three score and 10.

# NEWS of the STATE



## ADAMS

**Society News.**—Donalee L. Tabern, Ph.D., head of the department of radioactive pharmaceuticals, Abbott Laboratories, North Chicago, addressed the Adams County Medical Society, March 12, on "Radioactive Isotopes in the Diagnosis and Treatment of Disease." Dr. Franklin E. Walton, associate professor of clinical surgery at Washington University School of Medicine, St. Louis, discussed "Cancer of the Stomach" before the society recently.

Dr. Otto Berdach of Jacksonville, clinical director of psychiatry at the Jacksonville State Hospital, spoke of the work of the new mental health center in Quincy. Miss Dorothy Hoffstadt of the Adams County Medical Secretaries and Assistants Club told of organizational plans for a state chapter.

**Personal.**—Lucius Clark Hollester, Jr. M.D., orthopedic surgeon has joined the physicians and surgeons clinic in Quincy.

**Annual Public Relations Day.**—On May 14 the Adams County Medical Society held its Annual Public Relations meeting day to which all physicians and dentists and their assistants and secretaries, pharmacists, nurses, technicians, public health personnel, hospital administrators, record clerks and trustees and medical society auxiliary members were invited. Leo Brown, director of public relations of the American Medical Association, was the featured speaker.

## COOK

**Institute of Medicine Meeting.**—Barry J. Anson, Ph.D., professor of anatomy at Northwestern University Medical School, addressed the Institute of Medicine recently on "Monsters and Monstrosities in the Collected Works of Ambroise Pare." Dr. Michael L. Mason, professor of surgery at Northwestern, also spoke on "Paracelsian Surgery."

**Society News.**—Dr. Louis B. Newman gave a series of lectures to the Honolulu County Medical Society, the Tripler General Hospital and to the staff of the Veterans Administration Regional Office in Honolulu in February. "Physical Medicine and Rehabilitation and Its Role in the Total Medical Management of the Disabled" was covered by Dr. Newman who is chief of physical medicine and rehabilitation service, Veterans Administration Research Hospital, Chicago. Dr. George C. Ham, professor and chairman of the department of psychiatry, University of North Carolina School of Medicine, Chapel Hill, North Carolina, gave one in the series of lectures presented by the North Shore Health Resort on "Psychiatric Problems in Medical Practice." Dr. Ham discussed "The Management of the Multiple Complainer." Dr. Maurice H. Cottle, professor and head of the department of otolaryngology, Chicago Medical School, conducted a course in surgery of the nasal septum and external nasal pyramid in New Orleans, under the joint auspices of the departments of otolaryngology of Tulane University School of Medicine and the Louisiana State University.

**Symposium on Diabetes.**—A symposium on the clinical and public health aspects of diabetes was held at the Sherman Hotel, Chicago, May 11-12, under the joint sponsorship of the Chicago Diabetes Association, Chicago Board of Health, The Illinois Department of Public Health and the U. S. Public Health Service. In addition to a demonstration of the use of testing equipment for screening programs, the subjects included the Degenerative Complications of Diabetes, the Juvenile Diabetic and Pregnancy in Diabetes. Speakers included Dr. Henry T. Ricketts, president, American Diabetes Association; Dr. Arthur R. Colwell, professor and chairman, department of medicine, Northwestern University; Dr. Arnold B. Kurlander, chief, chronic diseases

program, U. S. Public Health Service; and Dr. Hugh L. C. Wilkerson, director of Diabetes Research and Training Center, Boston. The course was approved by the Illinois Academy of General Practice for Category II (informal) postgraduate credit.

**Twenty Faculty Members at Northwestern Receive Public Health Service Research Grants.**—Public Health Service research grants totalling more than $198,000 were awarded to twenty faculty members at Northwestern University medical school.

Largest grants were for the study of heart disease, kidney disease and the nervous system. Dr. William B. Wartman, professor and chairman of pathology, received $17,500 for the chemical study of the cells in the heart muscle injured by heart disease. Drs. Leslie P. Arey, professor and chairman of anatomy, and Ray S. Snider, professor of anatomy, received $17,000 for research on the effects of radioactivity on the nervous system. Dr. David P. Earle, professor of medicine, received $16,000 for research on kidney disease and edema.

Other grants for studies on the nervous system went to Dr. Loyal Davis, professor and chairman of surgery, who will investigate the effect of brain lesions on stomach secretions, and to Dr. E. A. Zeller, professor of biochemistry, who will study the distribution and functions of enzymes in nerves. Dr. Zeller also received a grant to study substances that combat tuberculosis.

Hormones of the adrenal glands will be studied by Dr. Morris A. Lipton, assistant professor of medicine, and the effect of stress on allergy will be studied by Dr. Samuel M. Feinberg, professor of medicine.

The effects of immune serum on tumor cells and the mechanism of inhibition of cancer will be investigated by Drs. Robert Schrek, assistant professor of pathology, Frederick Preston, assistant professor of surgery, and Willard T. Hill, associate professor of pathology.

In biochemistry Drs. Smith Freeman, chairman and professor, and Leonard C. Smith, instructor, will conduct research projects on amino acids and on bone metabolism.

Other grants went to Dr. Jules H. Last, assistant professor of medicine, to study artery diseases, to Dr. Roy M. Whitman, assistant professor of neurology and psychiatry, to study psychosomatic diseases, and to Drs. Harry B. Harding, associate professor of bacteriology, and Opal E. Hepler, associate professor of pathology, to study laboratory tests for virus and rickettsial diseases.

In physiology Drs. John S. Gray, professor and chairman, and Fred S. Grodins, professor, will study the regulation of lung function. Dr. Orion H. Stuteville, lecturer in surgery and professor of maxillo-facial surgery in the dental school, will investigate fractures of the jaw bones.

**Symposium on Mis-Diagnoses.**—The Chicago Heart Association presented a symposium on Mis-Diagnoses at the Drake Hotel, March 13. Dr. William H. Wehrmacher, instructor in medicine, Northwestern University Medical School, gave the introduction and Dr. Aldo A. Luisada, associate professor of medicine, division of cardiology, Chicago Medical School, presented the summary. Participants were Drs. Aaron B. Shaffer, resident in medicine and associate, cardiovascular department, Medical Research Institute, Michael Reese Hospital; David W. Hines, resident physician, internal medicine, Veterans Administration Research Hospital; William Deardorff, resident physician, internal medicine, Veterans Administration Research Hospital and Steven J. Spinnuzza, associate, department of medicine, Cook County Hospital, attending physician, Ravenswood Hospital. Discussants in the course were Drs. Earl N. Silber, research association, cardiovascular department, Medical Research Institute, Michael Reese Hospital; Emmet B. Bay, professor of medicine, University of Chicago School of Medicine; and W. R. Meadows, currently on the staff of the Veterans Administration Hospital, Livermore, California.

**Course in Neuromuscular Diseases of Children.**—A two week intensive course in neuromuscular diseases of children, with special emphasis on cerebral palsy, will be held at the Cook County Graduate School of Medicine, June 18-29. The intensive, didactic and clinical course is designed for pediatricians, orthopedists, neurologists and physiatrists interested in the care and treatment of children with neuromuscular handicaps. It will be under the direction of Dr. Meyer A. Perlstein. Emphasis will be placed on the practical clinical aspects of treatment and rehabilitation procedures. The course will include several field trips to demonstration clinics, and treatment centers. The fee for the course, which is $225, includes the cost of luncheons as well as the expenses of travel, meals, and accommodations on the various trips. Registration in the course is limited. For further information, write to John W. Neal, Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois.

**Neurologists Address Chicago Society.**—Dr. Joseph R. Brown of the section of neurology, Mayo Clinic, Rochester, Minn., and Dr. George Schaltenbrand, director of the Neurologische Universitäts-Klinik, Würzburg, Germany, were the speakers at the monthly meeting of the Chicago Neurological Society, April 17. Their papers were presented under the auspices of the Leo A. Kaplan Memorial Lectureship, affiliated with the Phi Delta Epsilon Foundation of Chicago, and the Chicago Neurological Society.

Sir Charles Symonds, consultant neurologist at Guy's Hospital and National Hospital for Nervous Diseases, London, was the speaker at the May 1 meeting.

**Personal.**—Dr. Joseph K. Narat, research assistant in the department of surgery, University of Illinois College of Medicine, will deliver lectures on "Recent Progress of American Surgery" before surgical societies of Rangoon, Burma; Bangkok, Thailand, and Kyoto, Japan. Arrangements for additional lectures are being made by the Department of State's professional activities division.

## DUPAGE

**County Health Exhibit in Wheaton.**—On March 28 an exhibit explaining operations of health and welfare services was on display at the DuPage county health department headquarters in Wheaton. Laboratory, clinic, nursing and sanitation were among the subjects featured in the exhibit which was titled "Healtharama." The exhibit was sponsored by the county public health council, whose chairman is Mrs. Sven Bramsen of Elmhurst.

## KANKAKEE

**Dr. Norbury Speaker at Open House.**—Dr. F. Garm Norbury of Jacksonville, President of the Illinois State Medical Society, was the principal speaker at the open house at Manteno State Hospital, April 29.

## LAKE

**Membership Booklet.**—The Lake County Medical Society recently published a compact booklet in mimeographed form which presents the names, addresses and telephone numbers of the officers, the committees of the society, and a complete list of the members of the society together with their addresses. The booklet is convenient and is easy to handle.

## MASON

**Physician Enjoys Country Practice.**—"Life is better than ever for the country doctor" according to Dr. William A. Steele, as reported in the Chicago Daily News, March 9. Dr. Steele, who will observe his eighty-ninth birthday in November, has been practicing in Havana for nearly fifty years. He graduated from the University of Missouri and Barnes Medical College then went into practice in Carmi, Illinois. After eight years, he went to Chicago to specialize in eye, ear, nose and throat work, renewing his studies at St. Mary's Hospital and Rush Medical College in Chicago. Although Dr. Steele still maintains office hours every day but Sunday and Thursday, he devotes his spare time in a completely equipped woodworking shop in his home, making furniture and cabinetwork.

## PEORIA

**Society News.**—Dr. R. O. Muether, associate professor of internal medicine, St. Louis University Medical School, St. Louis, addressed the Peoria Medical Society, March 20, on "Anemia — Diagnostic Aspects."

## SANGAMON

**Personal.**—Dr. Erwin M. Janzen has become associated with Dr. William DeHollander in the practice of radiology at St. Johns Hospital, Springfield.

## WINNEBAGO

**Dr. Bettag Addresses Mental Health Conference.**—Dr. Otto L. Bettag, director of the Illinois Department of Public Welfare, gave the keynote address, "Medicine in Public Welfare," at a county-wide mental health conference in Rockford, March 23. The conference was sponsored by the Woman's Auxiliary to the Winnebago County Medical Society.

Dr. Bettag's talk was followed by a symposium on mental health services and a panel on rehabilitation aspects of mental health.

**New Members.**—Four new members were accepted into the Winnebago County Medical Society recently. According to the society's bulletin, this brings the total membership to two-hundred and twenty with about two hundred physicians practicing in the county at the present time. The new members are Drs. John A. Martin, III, who is currently associated with Dr. J. S. Moffatt in the Brown Building, Rockford; Thomas M. Jaquet who is serving at the Rockford Memorial Hospital; Chester Roe, Jr., presently on the staff of the Medical Clinic of Rockford and Frank Nelson Suma, who is also associated with the Medical Clinic of Rockford.

## GENERAL

**Progress in Health Services.**—"Age at Death in the United States" is the subject of a booklet, February 1956, brought out by the Health Information Foundation, 420 Lexington Avenue, New York 17, New York. The graphs used to illustrate the review of mortality rates from various causes of death make this simple booklet clearly understandable. The materials were prepared by the Health Information Foundation's research department, and are from the Foundation's current study of "Fifty Years of Health Progress," at two year survey to document the great improvement in medical care and health services in this country.

**Chicago Physician Among Bordon Award Recipients.**—Dr. Charles Huggins, professor of surgery and director of the Ben May Laboratory for Cancer Research at the University of Chicago, was one of nine scientists to receive the Borden Award, consisting of a gold medal and $1,000. According to the former report released by the Borden Company Foundation, Inc., Dr. Huggins was selected for the Borden Award of the Association of American Medical Colleges for his outstanding contributions in the field of cancer research, particularly the relationship between the endocrine glands and cancer. He first demonstrated that deprivation of the male hormone by castration or the administration of estrogenic compounds curbed the activity of prostatic cancer and its metastases. He then extended his work to show that by bilateral adrenalectomy certain tumors of the mammary gland will be likewise halted in their further growth and

spread of metastases. In recent work he has been able to identify by examination of their basic cellular composition which of the various tumors will respond to this new type of treatment.

**"Your Doctor Speaks" on FM Station WFJL.—** The following physicians have recently appeared in transcribed broadcasts of FM Station WFJL, Thursday evenings at 7:45 p.m. The series, entitled "Your Doctor Speaks", is presented by the Educational Committee of the Illinois State Medical Society:

John A. Caserta, clinical instructor in surgery, Stritch School of Medicine of Loyola University, March 29, on Peptic Ulcer.

Theodore A. Fox, assistant professor of orthopedic surgery, University of Illinois College of Medicine, April 5, on Tuberculosis of the Bones and Joints.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

Charles I. Fisher, instructor in medicine, Northwestern University Medical School, Woman's Auxiliary to the Northwest Branch of the Chicago Medical Society, January 24, on Safe Reducing.

Mrs. Jerome L. Koch, R. N., chairman of the State Careers Committee of the Illinois League for Nursing, Woman's Auxiliary to the Jackson Park Branch of the Chicago Medical Society, April 3, on Nursing.

Harry H. Boyle, assistant professor of pediatrics, Northwestern University Medical School, Hazel Crest Community Health Council, April 5, on Understanding the Pre-School Child.

Joseph A. Bertucci, assistant clinical instructor in pediatrics, Stritch School of Medicine of Loyola University, William Hatch Mother's Circle, April 10, on Our Pre-Teen Children.

Lawrence Breslow, clinical assistant professor of pediatrics, University of Illinois College of Medicine, Daniel Boone Parent-Teacher Association, April 18, on Proper Sex Education.

Danely P. Slaughter, assistant professor of surgery and director of Outpatient Tumor Clinic, University of Illinois College of Medicine, Licensed Practical Nurse Association of Illinois, April 25, on Cancer.

Charles I. Fisher, instructor in medicine, Northwestern University Medical School, Woman's Auxiliary to the North Shore Branch of the Chicago Medical Society, April 26, on Heart Disease.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

Burtis E. Montgomery, Councilor for the Ninth District and chairman of the Advisory Committee to the Illinois Public Aid Commission, Macoupin and Montgomery County Medical Societies, Carlinville, March 27, on Public Aid Assistance.

A. Beaumont Johnson, II, assistant attending neurosurgeon, Presbyterian Hospital and associate neurosurgeon, Cook County Hospital, Champaign County Medical Society, Champaign, April 12, on Space Occupying Lesions of the Central Nervous System.

Ralph T. Lidge, instructor in orthopedic surgery, University of Illinois College of Medicine, La Salle County Medical Society, Ottawa, April 13, on Common Orthopedic Problems.

David I. Abramson, professor and head of the department of medicine and rehabilitation and professor of medicine, University of Illinois College of Medicine, Iroquois County Medical Society, Watseka, April 17, on Thrombophlebitis and Phlebothrombosis.

Winston H. Tucker, Public Health Director of Evanston, Montgomery and Macoupin County Medical Societies, Litchfield, April 18, on Poliomyelitis.

## DEATHS

Robert I. Barickman★, Streator, who graduated at the University of Illinois College of Medicine in 1916, died March 9, aged 66. He had practiced medicine in Streator for 40 years.

Lewis Rawlings Brewer★, Oak Park, who graduated at the University of Illinois College of Medicine in 1926, died February 26, aged 54, of carcinoma of the left lung with metastasis of the liver. He was a member of the staff of the Oak Park Hospital.

Ernest S. Cleveland★, retired, formerly of Chicago, who graduated at the Chicago College of Medicine and Surgery in 1913, died March 9, aged 70, in Indianapolis. He was medical director for Carson Pirie Scott for 41 years.

Justin M. Donegan★, Kenilworth, who graduated at the State University of Iowa College of Medicine in 1939, died March 7, aged 44. He was chairman of the Presbyterian Hospital Department of Ophthalmology and associate professor of ophthalmology at the University of Illinois College of Medicine.

John D. Ellis, retired, formerly of Chicago, who graduated at Rush Medical College in 1911, died March 9, aged 69, in Denver. He was formerly senior surgeon at St. Luke's Hospital, Chicago.

Robert W. Elworthy★, Elmhurst, who graduated at Northwestern University Medical School in 1926, died March 15, aged 55. He had practiced medicine in Elmhurst for 25 years.

John R. Harger★, retired, formerly of Oak Park, who graduated at Northwestern University Medical School in 1906, died March 20, aged 79, in Alliance, Ohio, at the home of his daughter, where he had been living since his retirement. He was a former president of the Chicago Medical Society, a member of the staffs of the Garfield Park, Cook County and Illinois Masonic Hospitals, and a professor of surgery for 15 years at the Chicago Medical School.

Junie Joseph Hinckley, retired, Westfield, who

★Indicates member of the Illinois State Medical Society.

graduated at the Hahnemann Medical College and Hospital in 1896, died in the Paris, Illinois Hospital, December 29, aged 84.

Norbert Andrew Klucikowski★, Evergreen Park, who graduated at the University of Illinois College of Medicine in 1943, died December 16, aged 39, of acute myocardial infarction. He was a member of the staff of the Little Company of Mary Hospital.

George R. McAuliff★, Chicago, who graduated at Rush Medical College in 1911, died April 3, aged 71. He was a member of the Chicago Ophthalmological Society.

Ernest C. McGill★, Evanston, who graduated at Rush Medical College in 1917, died March 31, aged 66. He was a former president of the medical staff of St. Francis Hospital, Evanston.

Rosanna N. McKenney★, Winnetka, who graduated at Loyola University School of Medicine in 1922, died March 25, aged 58. She was formerly school physician at New Trier High School and of Evanston School District 76.

Rudolph J. Mroz★, Chicago, formerly of Rockford, who graduated at the University of Illinois College of Medicine in 1922, died March 16, aged 58. He was a member of the American Academy of Orthopaedic Surgeons and the Clinical Orthopaedic Society.

George William Pridmore, retired, Vandalia, who graduated at Beaumont Hospital Medical College, St. Louis, in 1896, died November 22, 1954, aged 84.

Harold A. Ramser★, Chicago, who graduated at Rush Medical College in 1916, died March 11, aged 65, in Mexico City while on a vacation.

Arthur Joe Rissinger★, Mason City, who graduated at the University of Illinois College of Medicine in 1925, died October 17, aged 59, of cerebral hemorrhage. He was past-president of the Board of Health of Lake Forest and health officer of Lake Bluff.

Bernard A. Weber★, Olney, who graduated at St. Louis University School of Medicine in 1926, died suddenly January 27, aged 56.

Ladislaus P. Wieczorek★, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1915, was killed by an automobile as he returned home from his office, March 22. He was 72.

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★Indicates member of the Illinois State Medical Society

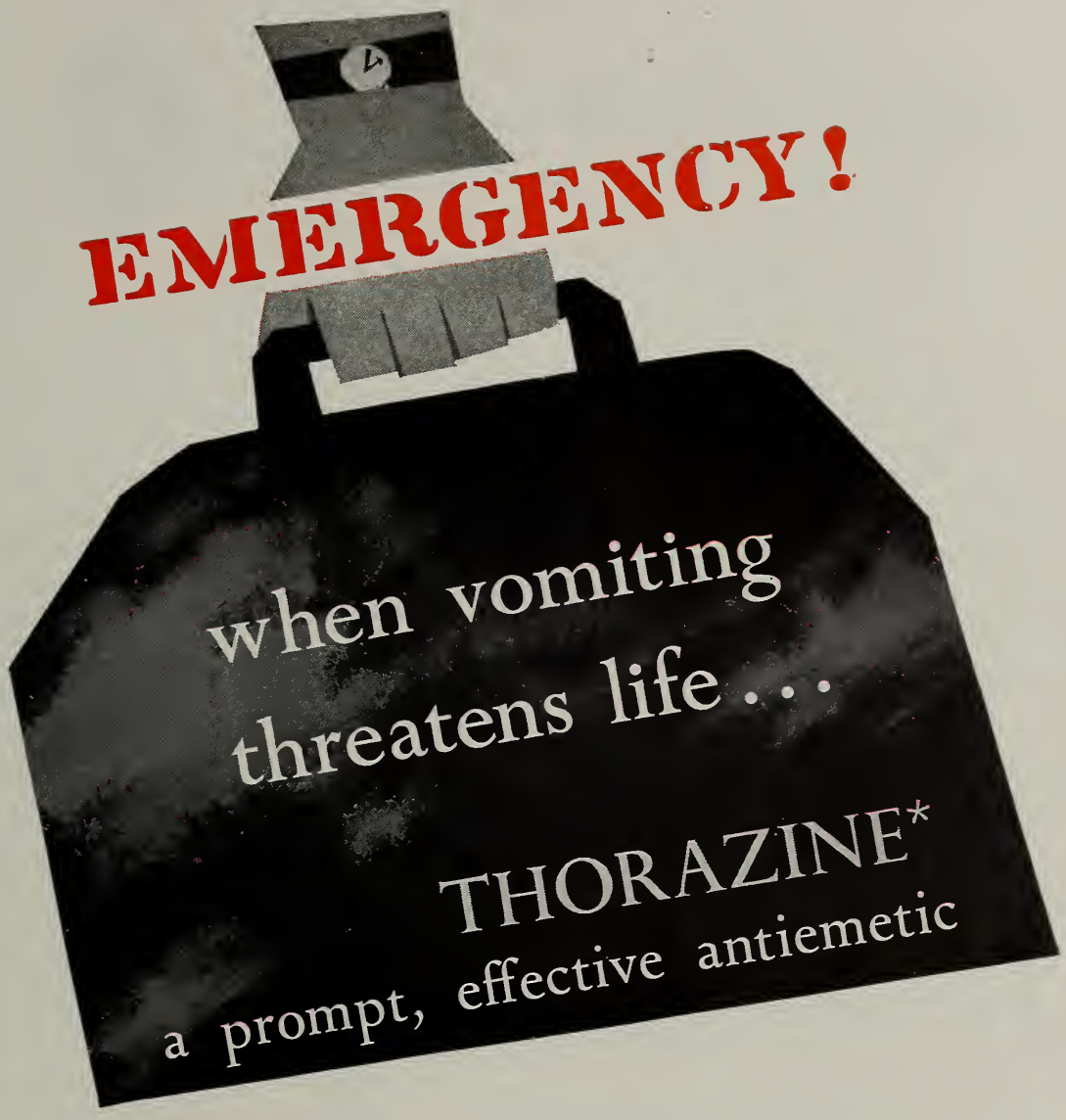
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## A rectal on every patient

Over 50 per cent of carcinomas of the colon can be palpated by rectal examination; approximately 75 per cent can be seen on sigmoidoscopy, and practically all of the remainder can be found by barium enema studies. *John H. Remington, M.D. Delay in the Diagnosis of Carcinoma of the Colon. New York J. Med. Aug.* 15, 1955.

## "Christians awake"

In our sanatorium we sent a lot of patients home on leave for Christmas; in fact, in one ward, only six Pakistanis and an East African were left. But the carol singing nurses who visited the ward at midnight on Christmas Eve firmly started their program with "Christians Awake." *Lancet, Jan.* 14, 1956.




'Thorazine' is available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

'Thorazine' should be administered discriminately and, before prescribing, the physician should be fully conversant with the available literature.

*for emergencies — always carry*
*'Thorazine' Ampuls in your bag*

*Smith, Kline & French Laboratories, Philadelphia*

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.

# BOOK REVIEWS

HAND SURGERY. Surgery in World War II, Medical Department United States Army. Edited by Sterling Bennett, M.D.

The purpose which underlay the preparation of this work was fundamentally an attempt to record what has been learned in hand surgery in military practice, so that "such knowledge may be" and it is hoped will be utilized in any future conflict.

It is a recitation of experiences in World War I, but more particularly World War II, and also of conclusions arrived at in the case of such injuries in those injured in these great conflicts.

In World War I there was no distinction between hand injuries and other injuries in so far as to what center they were assigned. In World War II several highly specialized centers were operated for care of the hand injuries. The end result in the hundreds of cases treated iminently justified the procedure.

The need for a compilation of specific treatment and the after care and rehabilitation of hand care is exemplified in the following statistics:

"During the entire period of the war between the States (1861-65), there were among Federal soldiers 12,865 recorded cases of fractures of the bones of the hand and wrist due to shot injury. In addition, approximately 15,200 flesh wounds of the hand occurred."

The exact number of such injuries in World War II is not stated. But each of these hand centers reports the findings, the treatment and their opinions of their success and failure, recounting the great number of cases in the many different types of cases reported. So, the sum total of all hand and wrist cases must be almost beyond imagination.

This is not exactly a reference work. However, each center tells its own story, delineating personal ingenuity and point of view. Consequently since each center had almost every conceivable type of injury and complication, one has but to survey in the chapter from each center devoted to his particular problem, and he has a definite composite picture to reward him.

Major General George E. Armstrong, the Surgeon General, is to be complimented by the physicians for maintaining these centers, and then for enabling the great effort required to extract this information piece meal from the records.

The book has 447 pages, is well indexed and is printed by the U. S. Government Printing office and is for sale at $3.75 from the Superintendent of Documents, Washinton 25, D. C.

C. P. B.

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THE BILIARY TRACT. Julian A. Sterling, A.B., M.D., M. Med. S. C., F. A. C. S.—Staff Surgeon, Albert Einstein, Medical Center and Graduate Hospital, Williams & Wilkins Co., Baltimore. 424 pages. $10.00.

After quite thorough investigation of this book one can justify in detail the expression of the publisher in the book's jacket. "Conciseness and exhaustiveness," are the book's two most valuable qualities. Thoroughly yet briefly, it presents a correlation of clinical, laboratory, operative and functional data.

The author dispels confusion caused by the vast number of existing theories and treatments for biliary tract disease by outlining in detail

(*Continued on page* 51)

his choice of the most workable methods. With emphasis on these specific methods, the book becomes a practicable and an authoritative source for improved management and more efficient technique in treatment of biliary tract disease."

This book is entirely adequate for any practicing physician, student, general practitioner, surgeon or specialist in any category, and will be added to his library with satisfaction. Once consulted with a problem concerning the biliary tract in mind, the work will become well thumb marked and in no great length of time.

C. P. B.

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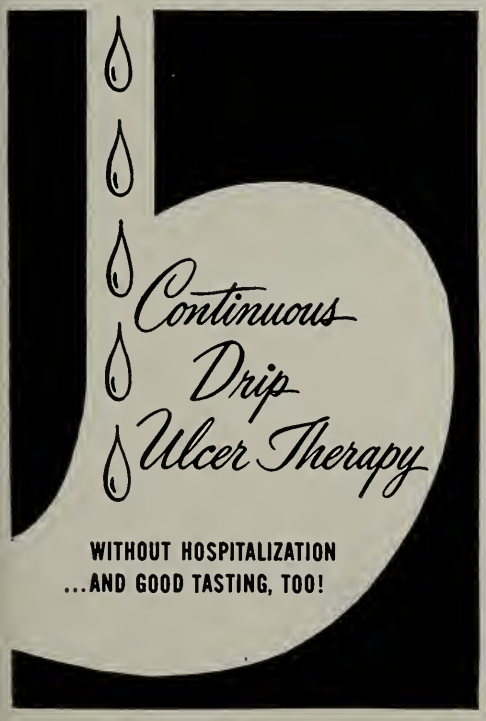
SALIVARY GLAND TUMORS By Donald E. Ross, M.D., F.A.C.S., F.I.C.S., F.R.C.S., Diplomate, The American Board of Surgery. Chief Surgeon, Ross-Loos Medical Group. Los Angeles, California.

"There is a deep dread of injuring the facial nerve. This leads to procrastination" and years go by before surgical intervention. Dr. Ross attempts in this book to "clarify and epitomize theories of origin and the pathology" of salivary gland tumors. He also has given in detail the surgical technique as used by himself for removal of these tumors. The book leads to the conclusion that "all should realize that these tumors can be removed adequately and yet the facial nerve can, except in rare cases, be saved.

The histogenesis of salivary gland tumors is presented quite thoroughly. Pathology is considered in considerable detail and with many cuts of miscroscopic findings. These are described in great detail and even the history of the cases from which they originated is submitted. The cuts are perhaps dull (as are all miscroscopic slides) and yet as they are observed with the descriptions they become more interesting.

The author portrays his technique for surgery on the parotid gland. This portrayal is nicely illustrated with many diagrammatic drawings. It

(*Continued on page* 54)


**HORLICKS CORPORATION**
***Pharmaceutical Division***
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# Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. *22*:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.



a "judicious combination..."

# for antiarthritic therapy

# SALCORT*

That cortisone and the salicylates have a complementary action has been well established.[1-5] In rheumatic conditions, functional improvement and a sense of feeling well are noted early. No withdrawal reactions have been reported.

One clinician states: "By a judicious combination of the two agents . . . it has been possible to bring about a much more favorable reaction in arthritis than with either alone. Salicylate potentiates the greatly reduced amount of cortisone present so that its full effect is brought out without evoking undesirable side reactions."[1]

## INDICATIONS:

Rheumatoid arthritis . . . Rheumatoid spondylitis . . . Rheumatic fever . . . Bursitis . . . Still's disease . . . Neuromuscular affections

## EACH TABLET CONTAINS:

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| Cortisone acetate . . . . . | 2.5 mg. |
| Sodium salicylate . . . . . | 0.3 Gm. |
| Aluminum hydroxide gel, dried . | 0.12 Gm. |
| Calcium ascorbate . . . . . | 60 mg. |
| (equivalent to 50 mg. ascorbic acid) | |
| Calcium carbonate . . . . . | 60 mg. |

* U.S. Pat. 2,691,662

1. Busse, E.A.: Treatment of Rheumatoid Arthritis by a Combination of Cortisone and Salicylates. Clinical Med. 11:1105 (Nov., 1955).
2. Roskam, J., VanCawenberge, H.: Abst. in J.A.M.A., 151:248 (1953).
3. Coventry, M.D.: Proc. Staff Meet., Mayo Clinic, 29:60 (1954).
4. Holt, K.S., et al.: Lancet, 2:1144 (1954).
5. Spies, T.D., et al.: J.A.M.A., 159:645 (Oct. 15, 1955).

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**The S. E. Massengill company**

# Meat...

## *and the Rehabilitation of Protein Depleted Patients*

Although the recommended daily allowance of one gram of protein per kilogram of body weight is adequate for the average healthy adult,[1] greater amounts may be needed in the rehabilitation of patients depleted in protein after severe infections, mechanical trauma, burns, or extensive surgery.[2] Protein needs for tissue regeneration during convalescence are high.

To speed rehabilitation of the protein depleted patient, top quality protein and calories should be given in generous quantity.[2] However, a high protein intake, 130 grams daily, at best induces a slow response.[3] Intakes at 3 or 4 times that level may produce considerably more rapid gain in weight, strength, and morale.[4,5] If mastication and swallowing are difficult, canned strained meats—such as used in infant feeding—may be used to advantage in the high protein diet.[2]

Lean meat, outstanding in contained top quality protein, may well be made the keystone of the high protein diet. Its abundance of vitamin B complex and essential minerals—iron, phosphorus, potassium, and magnesium—adds to its therapeutic value. Important also are its appetite appeal, its easy digestibility, and its virtual freedom from allergenic properties.


1. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953.
2. Co Tui: Review: The Fundamentals of Clinical Proteinology, J. Clin. Nutrition *1*:232 (Mar.-Apr.) 1953.
3. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, Univ. of Minnesota Press, 1950.
4. Burger, G. C. E.; Drummond, J. C., and Sandstead, H. R.: Malnutrition and Starvation in Western Netherlands, The Hague General State Printing Office, 1948, Part II, p. 91.
5. Co Tui; Kuo, N.H.; Chuachiaco, M., and Mulholland, J.H.: The Protein Depletion (Hypoproteinia) Syndrome and Its Response to Hyper-Proteinization, Anesth. & Analg. *28*:1 (Jan.-Feb.) 1949.


The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

**American Meat Institute**
Main Office, Chicago... Members Throughout the United States

EVERY WOMAN

WHO SUFFERS

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## BOOK REVIEWS (Continued)

is interesting and instructive.

Dr. Ross writes of parotid fistula, repair of Stinson's duct and facial nerve paralysis. In the latter he shows treatment in many varying conditions of the facial nerve, its repair, etc., and then means for plastic inprovement of the paralysis of the side of the face.

The volume is odd shaped, 11″×8½″, has 86 pages, an adequate index and a large list of references and sells for $7.50.

The book is worth reading.

C. P. B.

## BOOKS RECEIVED

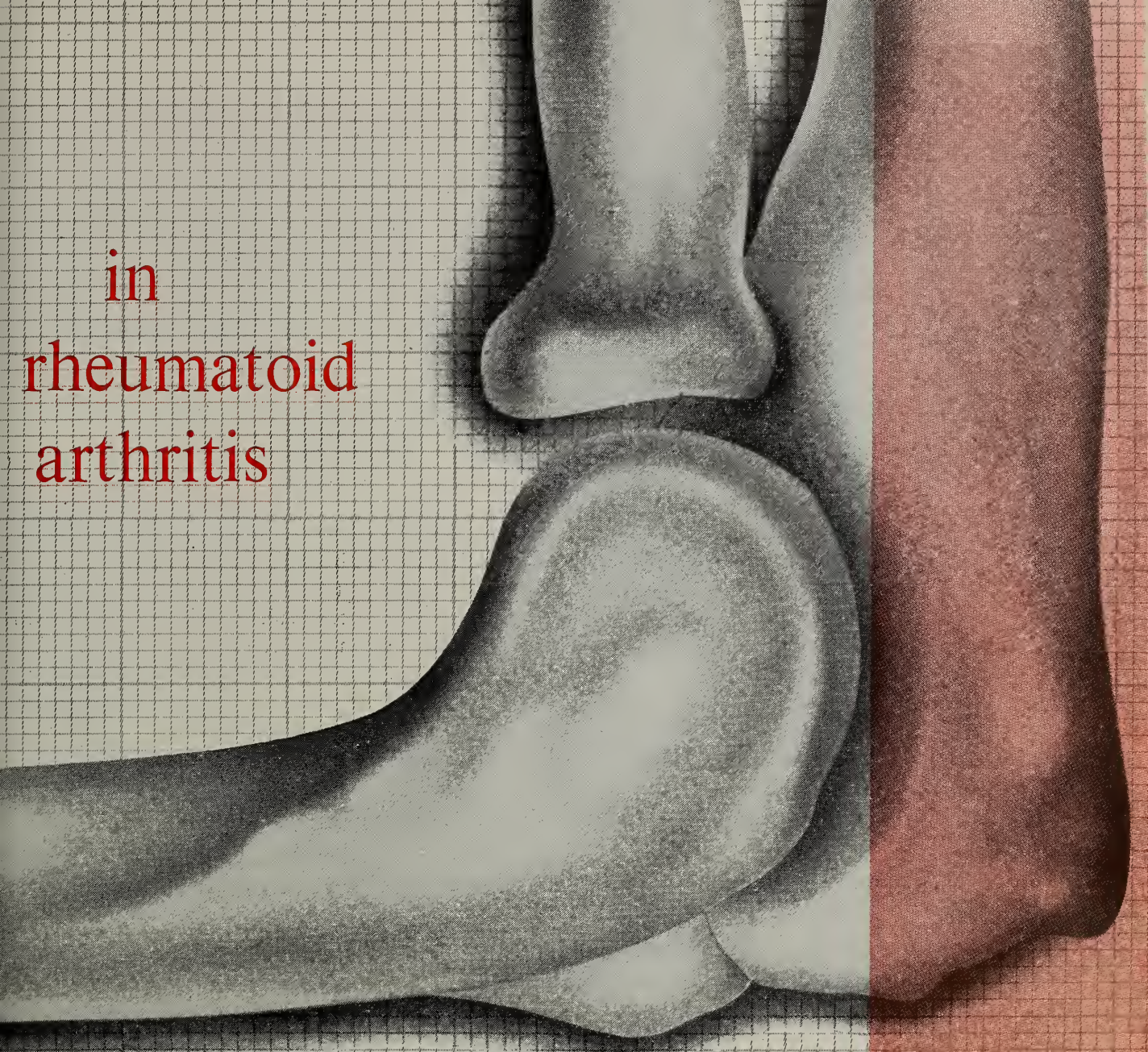
The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

UROLOGY. By B. G. Clarke, M. S., M. D., F. A. C. S., Associate Professor of Urology, Tufts University School of Medicine; Urologist, New England Center Hospital; Urologist-in-Chief, Boston Dispensary; Consultant in Urology, Boston Floating Hospital. By Louis R. M. Del Guercio, M. D., Assistant Resident Surgeon, St. Vincent's Hospital, New York. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, Toronto, London. $6.50.

ELECTROCARDIOGRAPHY. Fundamentals and Clinical Application. By Louis Wolff, M. D., Visiting Physician, Consultant in Cardiology and Chief of the Electrocardiographic Laboratory, Beth Israel Hospital; Assistant Clinical Professor of Medicine, Harvard Medical School. Second Edition. 342 pages. 199 illustrations. W. B. Saunders Company, Philadelphia, London, $7.00.

CLINICAL RECOGNITION AND MANAGEMENT OF DISTURBANCES OF BODY FLUIDS. By John H. Bland, M. D., Associate Professor of Medicine, University of Vermont College of Medicine. Second edition 522 pages. 109 figures. W. B. Saunders Company, Philadelphia and London, $11.50.

CLINICAL LABORATORY DIAGNOSIS. By Samuel A. Levinson, M. S., M. D., Ph. D., Director of Laboratories, University of Illinois Research and Educational Hospitals, Chicago, Illinois; Professor of Pathology, University of Illinois College of Medicine, and Robert P. MacFate, Ch. E., M. S., Ph. D., Chief, Division of Laboratories, Board of Health, City of Chicago; Director of Laboratories, Municipal Contagious Disease Hospital, Chicago; Director of Laboratories, Municipal Social Hygiene Clinic, Chicago; Senior Scientist® United States Public Health Service. Fifth Edition, thoroughly revised. 244 illustrations and 13 plates, 11 in color. Lea & Febiger, Philadelphia. $12.50.



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*replaces cortisone and hydrocortisone*
*permits treatment of more patients*

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- significantly less edema due to sodium retention
- excellent relief of pain, swelling, tenderness
- effective in smaller dosage

*T.M.

MC J-63-1255

## Protect livestock by immunization

In Brucella abortus infection there are two main methods of control. One resembles that in common use in the control of bovine tuberculosis; namely, the detection of infected animals and their removal from contact with healthy livestock, although the tests applied are quite different. The other embraces the use of a suitable vaccine. Although it has been possible to eradicate brucellosis from herds of cattle and even from areas of countries in the earlier stages of a campaign for the eradication of the disease, by detecting and removing infected animals, the incidence of the infection and the highly infective nature of the causal organism make it difficult to prevent reinfection of a herd. Recourse has to be made, therefore, to the protection of livestock by immunization. There are now available vaccines with high protective values and one especially is now being used throughout many parts of the world. This is a strain of Br. abortus of natural low virulence which, when injected into susceptible animals, sets up an immunity of high order against brucella infection. The vaccine is used in the living state and, although effective in bovines of all ages, is largely used on young stock. It has recently been shown that a single dose of the vaccine injected into young female bovines will give protection against natural infection of average virulence for four or even five pregnancies. This means that in most instances the protection so acquired remains during the whole of the animal's economic life. *Sir Thomas Dalling. Healthy Animals Mean More Food. WHO Newsletter* 8:1, *Nov.-Dec.* 1955 *via Ohio M.J. Jan.* 1956.

‹ ›

The treatment of pulmonary tuberculosis does not, of course, begin and end with the administration of antimicrobial drugs. That they are more effective than bed rest alone in arresting the process of tuberculosis, I believe no one will deny. It does not necessarily follow from this, however, that bed rest can be altogether discarded. We have indeed scarcely any information on the extent to which bed rest can be omitted or modified in the early phases of treatment. Carl Muschenheim, M.D. Am. Rev. Tuberc., July, 1955.


**APPROXIMATE COMPARATIVE ANTITUSSIVE AND ANALGESIC DOSES OF OPIATES**

1. To control cough 1/64 gr. Dilaudid is equivalent to 1/4 gr. codeine.
2. For analgesia 1/20 gr. Dilaudid will usually replace 1/4 gr. morphine or 1 gr. codeine. Dilaudid is given for pain relief, not for hypnosis.

• Dilaudid may be habit forming, and requires a narcotic prescription.

Dilaudid hydrochloride is available in various strength hypodermic tablets, in ampules, oral tablets and powder.

℞ *in cough*
*Dilaudid HCl ... gr. ss*
*Elix.Terp.Hydr..... ʒ iv*
*One teaspoonful every 3 or 4 hours. Children half this dose.*

Dilaudid®, brand of Dihydromorphinone, a product of E. Bilhuber, Inc.

Dilaudid
for pain and cough
BILHUBER-KNOLL CORP. *distributor*
ORANGE, NEW JERSEY




tablets

# 'V-Cillin-Sulfa'

(PENICILLIN V WITH TRIPLE SULFAS, LILLY)

## ...combine the superior oral penicillin and three sulfonamides

'V-Cillin-Sulfa' provides you greater control over a wider range of microorganisms. 'V-Cillin' (Penicillin V, Lilly) and sulfas used concurrently produce faster and more effective antibacterial action in certain infections. In general, the combination is most beneficial in mixed infections, infections due to bacteria only moderately susceptible to either agent, and conditions in which bacterial resistance might develop.

The much higher penicillin blood levels produced by 'V-Cillin' and the effectiveness and safety of the triple sulfas make 'V-Cillin-Sulfa' your most valuable preparation of its type.

DOSAGE: 1 to 2 tablets q.i.d.

SUPPLIED: Each tablet provides 125 mg. (200,000 units) 'V-Cillin' plus 0.5 Gm. sulfas—equal parts of sulfadiazine, sulfamerazine, and sulfamethazine.

ELI LILLY AND COMPANY

80TH ANNIVERSARY 1876 • 1956

## This is clinical material

The present hospital at Ibadan (Nigeria) is called Adeoyo and the staff, being from University College, will be transferred to the new hospital as each department there is completed. The clinical material is beyond the conception of anyone who has never left Europe. To Adeoyo come every morning 500 Yoruba women advanced in pregnancy. They will sit in the sun with their absolute patience and their quiet faces under magnificent head-dresses until in time they have been seen, examined, and advised. Thirty cases of ruptured uterus were admitted last year and 100 cases of tetanus. Into Adeoyo pour the road casualties for these people, so quiet and patient in the ordinary affairs of life, become Western when given control of an internal combustion engine. In rows, on trestles or stone benches, they sit outside each department quietly, the most common cause for a movement being when a mother swings her baby round from where it is bound on the small of her back so that she may suckle it. But there is constant excitement outside the X-ray department. Here there is a continual delivery of films which are passed from hand to hand, held up, and scrutinized against the African sun. The power of the X-ray photograph is held in excessively high esteem alike by the tribesman from the distant village and the newly qualified doctor. *Editorial, Brit. Med.J. Feb.* 18, 1956.

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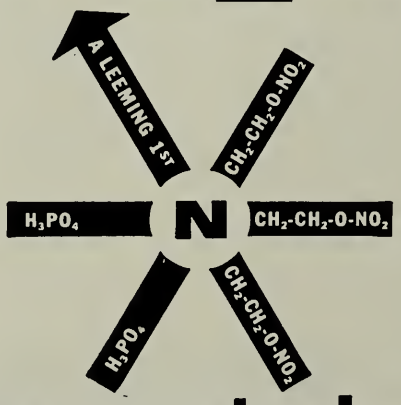
As a disease, tuberculosis is characterized by a moderate degree of infectivity, a long chronic course with tendency toward recurrence, and a high ultimate fatality in the group which develops active disease. An attack confers only relative immunity and for short periods. Unlike most acute communicable diseases, infection in tuberculosis is followed by disease in only a small percentage of instances. That is, the low morbidity rate is due to the high resistance of the host to invasion. In the majority of persons the infection remains latent for the rest of life but may become activated if host resistance is sufficiently lowered. Alton S. Pope, M.D., and John E. Gordon, M.D., Am. J. Med. Sciences, Sept. 1955.


**Metamine®**

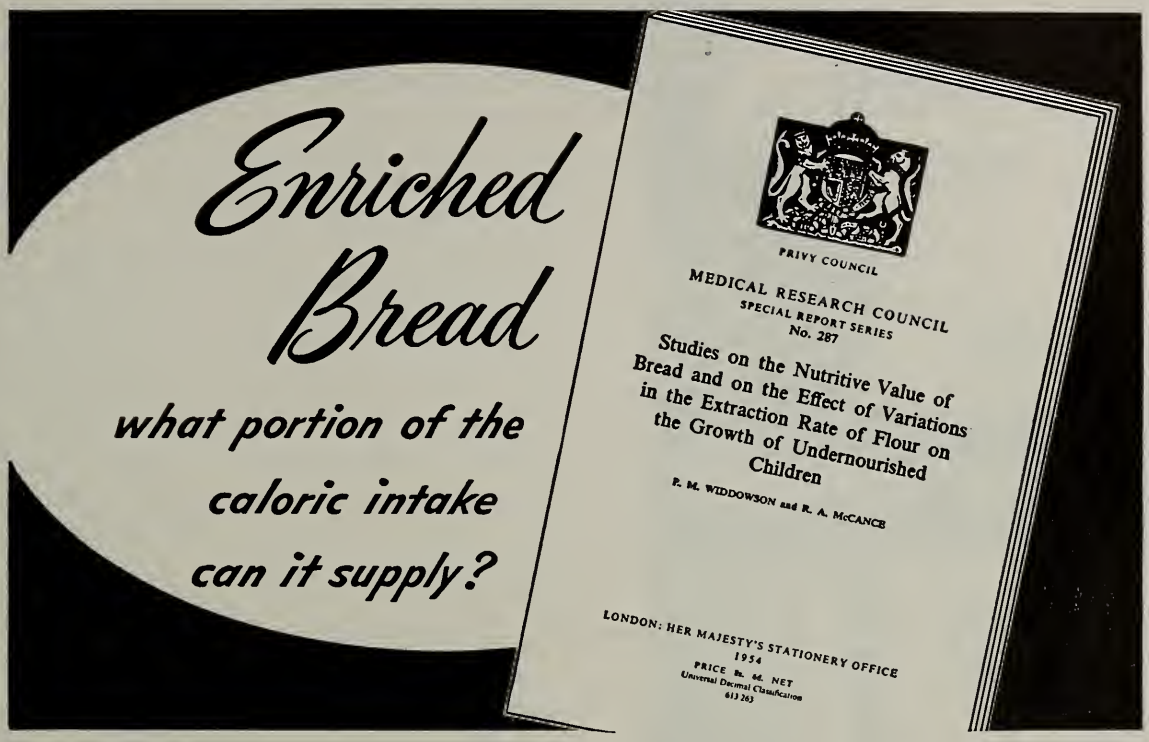
triethanolamine trinitrate biphosphate, LEEMING, tablets 2 mg. Bottles of 50 and 500
Dose: 1 or 2 tablets after each meal and at bedtime.

**smallest dose  lowest toxicity  unique amino nitrate**

**protects 8 out of 10 patients against angina pectoris**




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A striking observation was made in a recently reported nutrition study. Undernourished children in a German orphanage, placed on diets providing a high percentage of their total calories in the form of bread, not only improved in health, but "in spite of the simple diet provided" gained in weight and increased in height at a highly satisfactory rate.*

The children received daily supplements of vitamin A, 2000 I.U., vitamin D, 1000 I.U., and ascorbic acid, 25 mg.

In the words of the investigators: "One of the most striking findings, . . . and perhaps the most unexpected one, was the remarkable way in which the general condition of all the children . . . improved . . ."

"Probably the most important finding concerns the high nutritive value of wheat in any of the forms customarily consumed by man. . . . [The diets fed] provided undernourished children aged 5-15 years with all the nutrients required for a high rate of growth and development for a period of 18 months."

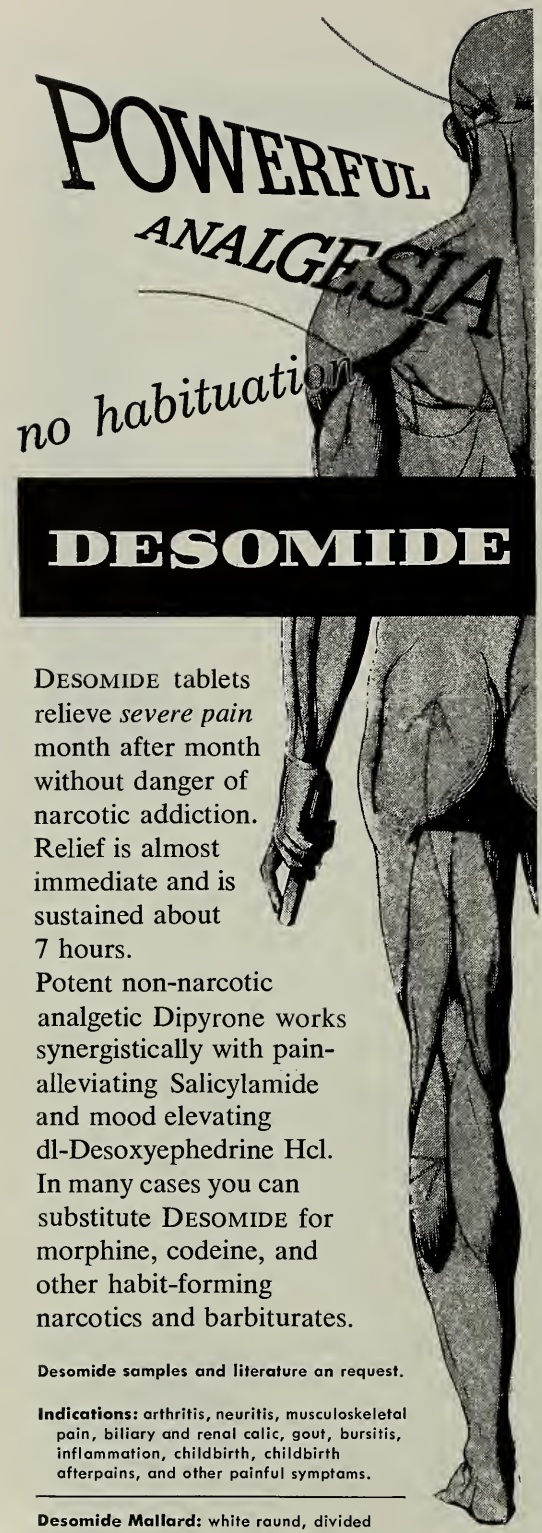
Enriched bread, made from 70 per cent extraction flour and very similar to enriched bread sold in the United States, was among the breads used. While the diets used in this study are not justified in this country with its abundant food supply, hence do not merit consideration for applicability here, they nevertheless serve to emphasize again the high nutritional value of enriched bread.



*Widdowson, E. M., and McCance, R. A.: Studies on the Nutritive Value of Bread and on the Effect of Variations in the Extraction Rate of Flour on the Growth of Undernourished Children, Medical Research Council, Special Report Series, No. 287, London, Her Majesty's Stationery Office, 1954.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

**AMERICAN BAKERS ASSOCIATION** 20 North Wacker Drive • Chicago 6, Illinois




DESOMIDE tablets relieve *severe pain* month after month without danger of narcotic addiction. Relief is almost immediate and is sustained about 7 hours.
Potent non-narcotic analgetic Dipyrone works synergistically with pain-alleviating Salicylamide and mood elevating dl-Desoxyephedrine Hcl. In many cases you can substitute DESOMIDE for morphine, codeine, and other habit-forming narcotics and barbiturates.

**Desomide samples and literature on request.**

**Indications:** arthritis, neuritis, musculoskeletal pain, biliary and renal colic, gout, bursitis, inflammation, childbirth, childbirth afterpains, and other painful symptoms.

**Desomide Mallard:** white round, divided tablet containing Dipyrone 100 mgs., Salicylamide 100 mgs., dl Desoxyephedrine Hcl 1.5 mgs.
AVAILABLE: Bottles, 100, 1000.

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**3021 WABASH, DETROIT 16, MICHIGAN**


## Handle with kid gloves

The people of some Asian and African countries, though they want contraceptive facilities as a right, have reservations which in their position we might share. Any suggestion that "the West" was trying to produce a substance with which foodstuffs could be doctored and the fertility of Eastern peoples reduced, might release a reaction far more powerful than the Indian Mutiny precipitated by the use of pig grease on cartridges. Such suspicions have been voiced; they have all the psychological attributes of an ideal rumor; and unguarded remarks about the beneficial effects of radiation in lowering the population of the world (in countries other than that of the speaker) may lend color to them. For such reasons the spirit in which biologists and doctors approach the problem, and their motives in working on it, may be as important to their ultimate success as is their technical proficiency. If, as many believe, we are developing in contraception a human right and a human freedom, it will do no harm to say so fairly often. *Contraception. Lancet, Jan.* 21, 1956.


**POST-GRADUATE COURSE IN SURGERY**

*Designed for candidates for the F.R.C.S.(C) and the American Board of Surgery*

The Surgical Staff of the Royal Victoria Hospital are conducting their 11th annual course in surgery designed especially for those wishing to write the F.R.C.S. (C) and the American Board of Surgery.

The course consists of two sections; the correspondence portion will commence on May 1 and will consist of selected reading with weekly written questions. The clinical and didactic full time course will be held at the Hospital in mid-August and will last 7 weeks.

All the required work will be presented by the various specialists and will consist of physiology, anatomy, pathology, X-ray in association with general and special surgery.

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(PLAIN)

Contains 55% mineral oil; pleasantly flavored. In bottles of 1 pint.

***also available***

**KONDREMUL WITH CASCARA**—0.66 Gm. *nonbitter* Ext. Cascara/tbsp.

**KONDREMUL WITH PHENOLPHTHALEIN**—0.13 Gm. phenolphthalein/tbsp.

KONDREMUL belongs in the picture whenever *strain-free elimination* is a "must." The softening and infiltrating action of KONDREMUL results in a soft, well-formed, easily passed stool . . . with no irritation, griping, or tenesmus. KONDREMUL is an outstanding mineral oil emulsion because of its high stability and the extremely small, uniform size of its oil globules, each held firmly in an envelope of Irish moss. No unpleasant leakage.

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PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

## What's Cooking

In the food field, a trend which has been increasing steadily for half a century is now zooming into high. I am speaking about the trend of precooked, packaged, ready-to-eat foods. The number of such products is multiplying more rapidly than ever. Recently, Mr. Paul S. Willis, of the Grocery Manufacturers of America, pointed out that about one-third of the grocery sales today involves items that did not exist ten years ago, and that about one-half of the items now being sold have been introduced since 1929. One has only to look around the average supermarket to see that even now it is possible to live without cooking — and I do not mean that we will all eat in restaurants although that too is increasing. Based upon our observations I can predict that the housewife of the future will practice the art of cooking only occasionally, as a hobby. The homemaker will have more time for other family duties and for cultural and recreational pursuits. *George P. Larrick, Federal Food and Drug Administration release.*

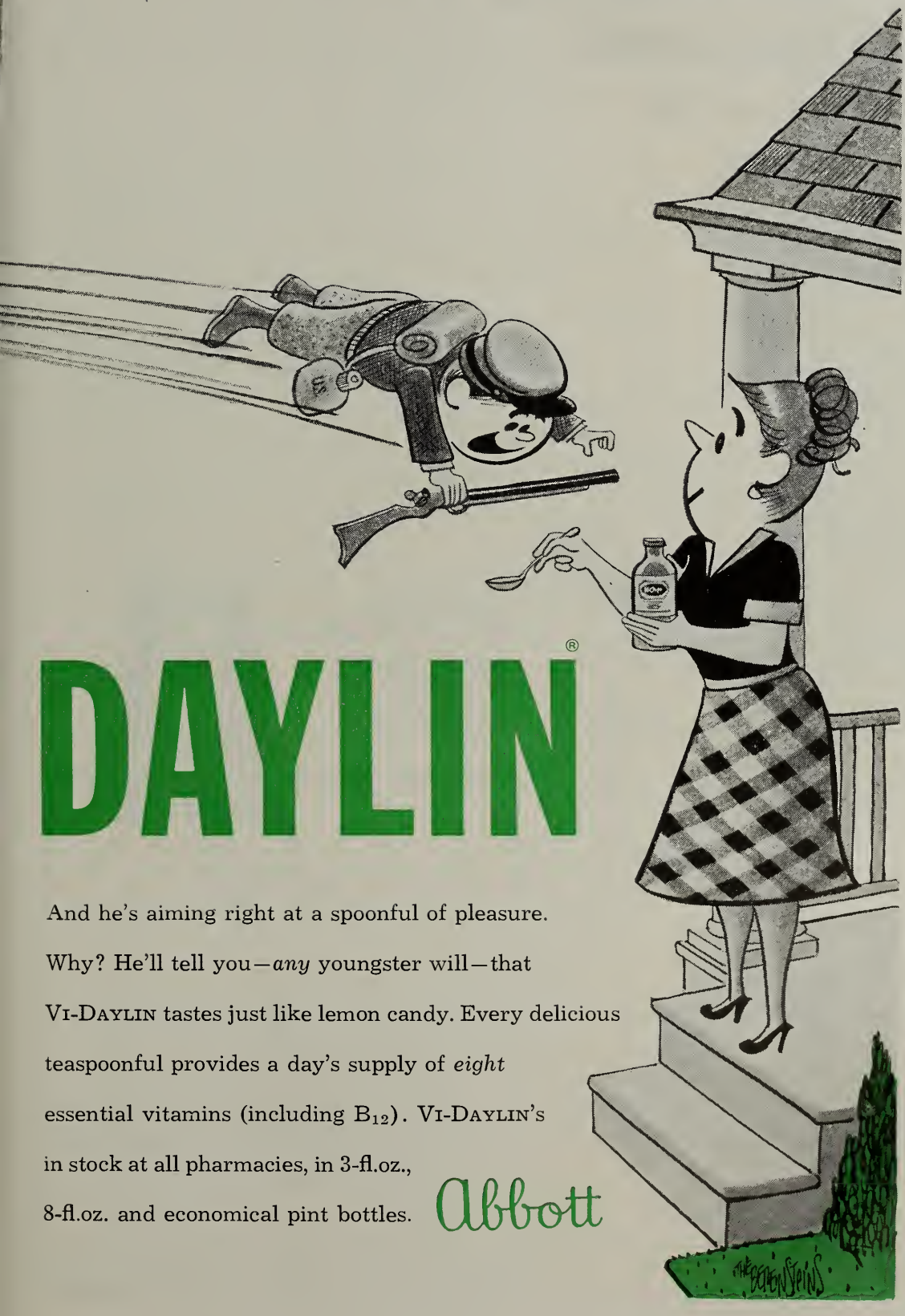
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MUMPS VACCINE

An effective immunizing antigen for prevention of mumps in children or adults where indicated. Immunizes for about one year.

Packages: 2 cc. vial (1 immunization)
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CHARLES L. DUNHAM, M.D., Washington, D.C., Director, Division of Biology and Medicine, Atomic Energy Commission

CHARLES HUGGINS, M.D., Chicago, Ben May Laboratory for Cancer Research

DWIGHT H. MURRAY, M.D., Napa, California, 1956-57 President, American Medical Association

EUGENE P. PENDERGRASS, M.D., Philadelphia, Professor of Radiology, University of Pennsylvania School of Medicine

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## Surgery for hydrocephalus

In the hands of most neurosurgeons, the most satisfactory procedure has been the shunting of cerebrospinal fluid through a small plastic tube from the lumbar subarachnoid space to a ureter. The procedure allows excretion of the spinal fluid in the urine but necessitates a nephrectomy on the affected side. Of 65 patients treated by this procedure, Matson reports 36 to be in excellent health and to exhibit normal or only slightly retarded development. While the surgical treatment of hydrocephalus still leaves much to be desired, sufficient progress has been made to indicate that any child with hydrocephalus deserves at least a neurological evaluation. *Edward C. Matthews, M.D. Diseases of the Nervous System. Ohio M.J. Jan.* 1956.

« »

If we could make a great bonfire of the thousands of laws we have in this country, and start all over again with only the Golden Rule and the Ten Commandments, I am sure we would get along much better.

— Coleman Cox

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- Insole extension and wedge at inner corner of heel where support is most needed.
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- **NOW AVAILABLE! Men's conductive shoes. N.B.F.U. specifications. For surgeons and operating room personnel.**
- By a special process, using plastic positive casts of feet, we make more custom shoes for polio, club feet and all types of abnormal feet than any other manufacturer.

*Write for details or contact your local* **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

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HARD-TO-KILL TRICHOMONADS

# EXPLODE

## WITHIN 15 SECONDS' CONTACT WITH VAGISEC LIQUID

WITH THE Davis technique,† using VAGISEC® liquid and jelly, flare-ups of vaginal trichomoniasis rarely occur. VAGISEC liquid actually explodes trichomonads within 15 seconds after douche contact.[1] Better than 90 per cent apparent cures follow use of this new trichomonacide,[2] developed as "Carlendacide" by Dr. Carl Henry Davis, noted gynecologist and author, and C. G. Grand, research physiologist.[3]

*No trichomonad escapes*—The overwhelming action of VAGISEC liquid dooms the trichomonad. One chelating agent and two surface-acting agents combine in attack to weaken the cell membrane, to remove waxes and lipid materials from the membrane surface, and to denature the protein. With its cell wall destroyed, the parasite imbibes water, swells and explodes. All this occurs within 15 seconds. Only scattered fragments remain.

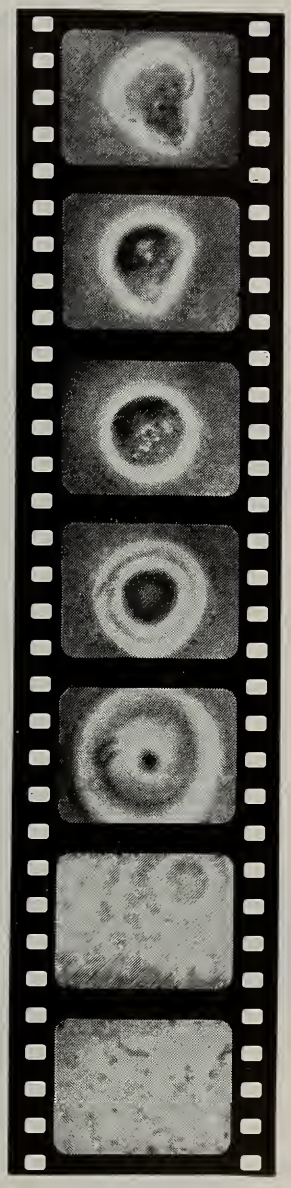
No other agent or combination of agents kills the trichomonad in this specific fashion or with the *speed* of VAGISEC liquid.[3] When the patient uses VAGISEC jelly as well—the recommended routine—these good effects continue indefinitely.[4]

*Reaches hidden trichomonads*—Unlike many agents, VAGISEC liquid thoroughly penetrates and dissolves the cellular debris and mucoid material lining the vaginal surface.[3] It reaches hidden trichomonads — often the cause of treatment failure — as well as parasites swimming freely in the canal.

*The Davis technique*—Office therapy with VAGISEC liquid is combined with home treatment. Both liquid and jelly are prescribed.

> OFFICE TREATMENT—*Wipe vaginal walls dry with cotton balls, then wash thoroughly for about three minutes with a 1:100 dilution of* VAGISEC *liquid. Remove excess fluid with cotton balls. Dr. Davis recommends three treatments the first week, two the second and one the third.*
>
> HOME TREATMENT—*Patient douches with* VAGISEC *liquid every night or morning and then inserts* VAGISEC *jelly. Home treatment is continued through two menstrual periods, but omitted on office treatment days. Douching is contraindicated in pregnancy.*

*Husband re-infects wife* — Since "trichomonads may be passed from the infected male to the uninfected partner during coitus,"[5] prevent re-infection by recommending the use of condoms. Specify RAMSES,® the finest possible rubber prophylactic, transparent, very thin yet strong; or XXXX (FOUREX)® skins, of natural animal membrane — pre-moistened. Your prescription of one of these brands insures the protection afforded by Schmid quality condoms and assures full acceptance of your regimen. At all pharmacies.



*Top to bottom:*
2 sec. CONTACTS
4 sec. COMPLEXES
6 sec. DISSOLVES
8 sec. DENATURES
10 sec. SWELLS
15 sec. EXPLODES
16 sec. SCATTERS

*References:* 1. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955. 3. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. *68*:559 (Aug.) 1954. 4. Davis, C. H. (Ed.): Gynecology and Obstetrics (revision), Hagerstown, Md., W. F. Prior, 1955, vol. 3, chap. 7, pp. 23-33. 5. Draper, J. W.: Internat. Rec. Med. *168*:563 (Sept.) 1955.

Active ingredients in VAGISEC liquid: Polyoxyethylene nonyl phenol, Sodium ethylene diamine tetra-acetate, Sodium dioctyl sulfosuccinate. In addition, VAGISEC jelly contains Boric acid, Alcohol 5% by weight.

VAGISEC, RAMSES and XXXX (FOUREX) are registered trade-marks of Julius Schmid, Inc.

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Each tablet contains:
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Samples and literature on request.

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## Aged rural people are happy

The lower incidence of the psychoses of old age among rural people might be due to the fact that aged rural people still have a place in their families and communities and are not considered burdens to their families. There are things for old folk to do and a place for them to live. In the city, old folk lose prestige and status once they have retired and are considered a financial burden. There is no room for old people in the city. In the city, more so than in rural areas, frustrations in a highly competitive environment are more frequent. They often result in the isolation of the individual, press him to lose contact with his environment, and lead to the bizarre personal worlds typical of the schizophrenic. In rural communities, the co-operative spirit of brotherly love often counteracts serious frustrations and hardships that individuals encounter. Rural people have a better sense of security in times of trouble and can depend upon neighbors to be good neighbors when needed most. In the city it is not uncommon that one doesn't even know the name of his next door neighbor. *Robert M. Frumkin and Miriam Z. Frumkin. Environment and Mental Illness. Ohio M.J. Jan.* 1956.


in whooping cough

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IS A UNIQUE REMEDY OF UNIQUE MERIT

Cuts short the period of illness and relieves the distressing spasmodic cough. Also valuable in Bronchitis and Bronchial Asthma.

In four-ounce original bottles. A teaspoonful every 3 to 4 hours.

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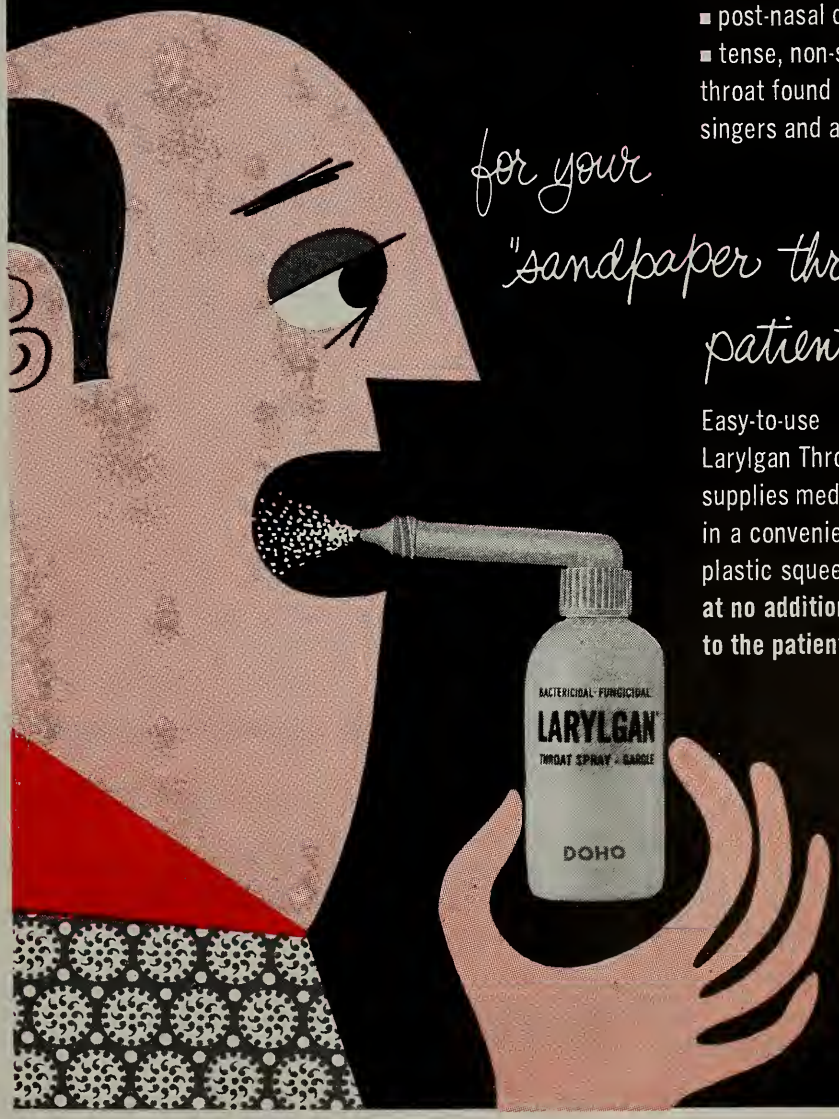
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(*Continued on page* 78)


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be closer to 66 per cent. At present, even the most sensitive tests are inadequate for clinical detection of most cases of coronary sclerosis. Over one-half of the 67 patients with diagnosis of myocardial infarction were examined postmortem. Of 36 cases, 17 presented evidence of a remote myocardial infarct without a clinical history. Acute myocardial infarction was found at autopsy in eight cases in which it had not been suspected clinically. In six patients, the clinical diagnosis of myocardial infarction was verified at autopsy. In other words, approximately one-half the cases of myocardial infarction were remote lesions, without a clinical history, which were discovered at autopsy; one-fourth were acute infarcts which were undiagnosed clinically; and the remaining one-fourth were diagnosed clinically and confirmed at autopsy. *Joseph I. Goodman, M.D. Coronary Atherosclerosis in a Chronic Disease Hospital Population. Geriatrics, Jan.* 1956.

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## The end of a "cure"

A follow-up on the English baldness "cure" (roniacol):

Of 36 controls, 32 showed no change and one was worse; of 42 subjects given roniacol, 39 showed no change and one was worse. *V. E. Lloyd Hart. M.R.C.P. et al. Brit. Med. J. Jan.* 21, 1956.

‹ ›

It is unlikely that much progress will be made in the future toward eliminating the micro-organisms that cause the diseases now endemic. Indeed, the fact that most members of the population will continue to harbor microbial agents that constitute a potential threat to health, even though not necessarily to life, must be accepted. Rene J. Dubos, Ph.D., J.A.M.A., April 23, 1955.



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**Vol. 109, No. 6**

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Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.



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# The Month in Washington

Washington, D. C.—As might be expected, a presidential commission's report on veterans' pensions that also goes into the subject of non-service connected medical benefits is stirring up another controversy.

The President's Commission on Veterans Pensions, headed by Gen. Omar Bradley, World War II leader and postwar Veterans Administrator, conducted a study covering more than a year in time and a wide range of subjects. It produced a 415-page report and a total of 70 recommendations.

The seven-man commission's report has this basic premise: military service in time of war or peace should be treated as discharging an obligation of citizenship and not of itself as a basis for future government benefits.

The commission made this additional point: ". . . under conditions of modern technology and warfare, the national defense might be served equally well by a civilian in a scientific laboratory or a war plant as by a uniformed serviceman — and in view of total war and atomic weapons, perhaps with greater personal hazard to the civilian. This further suggests that the special needs that veterans have because of military service should not be confused with the needs that all citizens have in common for such things as education, health services and economic security."

With this in mind, the commission proposes the gradual elimination of non-service connected benefits and observes: "Their justification is weak and their basic philosophy is backward looking rather than constructive." Such benefits, it adds, should be limited to a minimum level and retained only as a reserve line for veterans who fail to qualify for basic protection under Old Age and Survivors Insurance (Social Security).

The commission then goes one step further by recommending an end to the present automatic "presumption of service-connection" procedure. Now, presumption of service connection is automatic and mandatory for certain diseases if the condition is diagnosed within a specific period of time following discharge. Instead, the commission would substitute medical determination for chronic and tropical diseases, psychoses, tuberculosis and multiple sclerosis, with each case decided on its own merits.

Other recommendations: (1) increased reliance on the OASI system for certain veterans benefits, (2) prompt counseling of all veterans placed on compensation rolls as to VA and federal-state rehabilitation programs, and (3) requirement of reasonable medical or surgical treatment before payment of compensation.

Representatives of veterans groups called before the House Veterans Affairs Committee to comment on the Bradley study complained that some of its proposals would be "extremely destructive" to certain aspects of veterans compensation.

**NOTES**

Two committees of Congress, after long studies of problems of narcotics, barbiturate and amphetamine addiction, have come up with rec-

(*Continued on page 36*)



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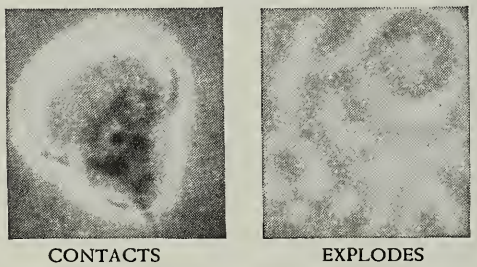
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*References:* 1. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955.

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## WASHINGTON (Continued)

ommendations that the U. S. tighten penalties on narcotics peddling and smuggling, outlaw heroin and set up a central unit in the Federal Bureau of Narcotics to keep track of known addicts. The proposals were made by the Senate Judiciary committee and a House Ways and Means subcommittee.

The House committee also suggested a law for more stringent controls over barbiturates and amphetamines.

The Senate committee rejected the proposal backed by the New York Academy of Medicine for "clinics" where known addicts could go for regular doses of narcotics.

‹ ›

U.S. Public Health Service is advising private physicians as well as health officers to increase their use of Salk poliomyelitis vaccine. Although supplies now lag behind demand, the expectation is that before summer is out the situation will be reversed. In line with this recommendation, PHS is urging that physicians use what supplies they have on hand immediately, depending on future production to take care of second and third shots.

‹ ›

Because the President signed the military career incentive bill promptly, physicians in uniform received their pay raises starting May 1. The minimum boost (after two years' service) is $50 per month, the maximum (after 10 years) $150.

‹ ›

Private-profit nursing homes, hospitals and some other medical facilities soon will have an opportunity to obtain U. S. loans from the Small Business Administration. The limit is $250,000 per project, the interest rate usually 6 per cent.

‹ ›

If there was any question about it, the AFL-CIO as a joint organization favors national compulsory health insurance, as each group did before the merger. The AFL-CIO stand was taken officially for the unions by Nelson Cruikshank in testimony before the House Ways and Means Committee on a bill for increased payments for the medical care of public relief recipients.

The
ILLINOIS
Medical Journal
Official Journal of The Illinois State Medical Society

JUNE, 1956
VOL. 109 NO. 6

# Medicine: an Art and a Science

F. Garm Norbury, A.M. M.D., Jacksonville

I HAVE naturally given some thought during this past year as to what I would say this afternoon. One of the honors and one of the duties of the presidency is to make this address. Perforce you have to listen to it. Perhaps you may go to sleep during it. I often do at medical and other meetings. That goes back to medical school days when a darkened amphitheatre and slides shown on the screen gave excellent opportunity for a nap. So I am not going to show any slides today. I went to sleep during a travelogue recently. My companion said I started to snore but a well directed kick took care of that.

I have read with interest some of the fine addresses my predecessors have given at a time like this. They have been forthright and constructive in their approach and their appeal. Our file of the Illinois Medical Journal at the Sanatorium goes back many years. I found some of my own "bursting into print" attempts as I looked over the bound volumes. What a letdown there was when comparing them to presidential addresses. One of my distinguished predecessors and fine friends, Dr. James Hutton, recently did me the honor to compare my style with that of another distinguished predecessor, Dr. Charles B. Reed. I cannot see the similarity but I thank him for the compliment.

*President's Address, Illinois State Medical Society Chicago, Illinois May 16, 1956*

Dr. Joseph Collins was a well-known neurologist and author in New York in the first quarter of this century. He headed up the Neurological Institute of New York. He was Professor of Neurology at the New York Postgraduate Medical School. He contributed many articles in clinical neurology and edited one of the earlier standard group assembly monographs. He also was an author of repute in associated fields. His books, "A Doctor Looks at Literature" and "A Doctor Looks at Biography," are two delightful volumes. He also wrote "Marriage and Medicine." My father knew Dr. Collins and regarded him highly. I was much impressed by his report of this physician and author; all the more so when I read those books.

I was tempted to take for a title of this afternoon's talk "A Neuropsychiatrist Looks at Medicine." This, however, would be plagiarizing on the works of Dr. Joseph Collins. It would also be presumptious on my part. During the one hundred sixteen years of the life of the Illinois State Medical Society there have been three physicians in this branch of medicine to whom the honor of the presidency has been given. Dr. Andrew McFarland of Jacksonville was the president in 1863. Dr. Harold N. Moyer of Chicago was president in 1900. I happen to be the third. Whether that betokens fear on the part of the House of Delegates of workers in this field or

whether it means too many of us have sat in ivory towers is not for me to say. For my part I hope I am a citizen first, a physician second and along with that a physician having a special interest in an increasingly important field of medical practice.

That special interest has in my opinion some applicability to organized medicine as well as medicine as a whole. So with this introduction I want to spend the next several minutes discussing some phases of it. The theme may be all too familiar to some of you who have heard me before. It is in the application of the subject of fields of consciousness to the practice of medicine wherein some difference may lie in these remarks.

Consciousness or the state of awareness may be roughly divided into two overlapping fields. One is the intellectual or *what* we *know* about people or things. The other is the emotional or *how* we *feel* about people or things. When we come to think about this we realize that in our daily lives how we feel about people or things actually influences us more than what we know.

The emotional or feeling side of consciousness is derived from the instincts of our predecessors in the evolutionary scale. It was when man with his God given brain appeared higher up on this scale that knowledge or the intellectual side began to be developed. Age begat priority for the feeling side. That is an anatomical, physiological, psychological and I believe a spiritual explanation for the inherent priority of feeling over knowledge.

Some years ago in Springfield as a part of a health series at the Y.M.C.A. I chose the subject "Poise or Nervousness" for a talk. I used the balance theme at that time. I have used it often since then. The balance between the well developed, well controlled intellectual and emotional fields of consciousness leads to mental health or poise. Disturbance of that balance with either overweighting or underweighting in either field leads to nervousness. One of the most complimentary remarks that can be made about an individual is that he or she is "well balanced."

More often than not what we know is affected by our desire to know or not to know. Desire in this instance is an example feelng tone. Friendship for a person, love of a person, dislike for a person, prejudice against a person has a direct association with what we may learn from that person or any idea he may promulgate. The same may be said for an abstract idea whether it be personal, social, religious, racial, national and so forth. Therefore it behooves us to be constructive in our approach to either personal or general situations. We must not let overfondness or undue dislike produce a type of response swayed by these feelings.

This general premise can be carried over into medicine as a whole. The intellectual field of consciousness of the physician and of the profession is related to the science of medicine, the emotional field to the art of it. Both phases are essential to the individual and to the group as a whole. They are also essential to our attitude towards, and care of our patients.

The intellectual component, the science phase, is a rigid discipline. Premedical preparation, basic studies in preclinical years, rigorous and vigorous application of these to clinical conditions all call for stimulation and utilization of the medical student's mind. Interneship, residency, postgraduate training, practice make demands for further continuing study; use of the intellectual field of consciousness. Whether it be teaching, research, practice or a combination of these there is always the demand for further search for knowledge. The student who does not work at the job flunks out. The physician who does not keep up may have a flash in the pan flame of brightness. He does not usually hold his place in the eyes of either his patients or colleagues. The last chapter in Osler's "Aequanimitas and Other Essays" is entitled "The Master Word in Medicine." That word is 'work'. Hence there is every occasion for a high degree of activity in the knowledge field of consciousness for the science of medicine.

Now to be consistent with the other part of the title there necessarily comes mention of the art of medicine. It is related to the emotional or feeling field of consciousness of the physician and the profession.

The attitude of the premedic, the satisfaction of acquisition of basic sciences, the desire to utilize knowledge gained in seeing patients all have feeling connotations to the medical student. He or she may not be aware of it at the time but another motivation of high feeling tone enters into the picture too, perhaps later on when dealing with patients. That is the humanitarian one of wanting to help sick people.

Studies were made some years ago at different medical schools as to why entering students wanted to become doctors. Naturally many motivations influenced these young people. Prestige of the profession, family tradition, economic advantages, research opportunities, stimulation by college professors, ambition for success and other factors were often among the primary reasons. Most of these show on analysis to have the ambition or achievement feeling connotation. The intellectual phase is secndary here. There was in the answers also a common denominator, often secondary, sometimes primary, of idealistic trend. "Helping people get well; operating on a sick man and see him recover; preventing disease" and similar terms appeared. These showed in entering students something more than a statement "many doctors drive Cadillacs" indicates. All this is in accord with the statement that our emotions rule us in everyday life more than our intellects.

How do these two fields affect the young physician starting out in practice? In these days there is often the obligation of wife and family to support as well as the office setup and equipment, to say nothing of the automobile. The need for income to meet these responsibilities lies heavy. It affects both the clinical practice and the development or building up a practice. Be it said to the credit of the young physicians whom I have known they hold onto both the desire to do good medical work and the attitude of good will towards their patients. They meet both the intellectual and emotional requirements of the science and the art of medicine. They take care of their patients. They rise to emergencies. They take part in community activities. I think they would do more of this latter if some of us older members of the community would let go of some of the positions we have attained. I think this applies to hospital staffs, governing boards of various bodies both medical and community. I do not hold with compulsory retirement at age sixty-five, perhaps that is personal because I'm going to be there in another year. Desire for retention of justifiably attained influence by our age group may stymie full development of intellectual and emotional satisfaction of younger individuals.

I think this applies relatively less in medicine than elsewhere. During the past several years, more during the past two years, I have had the opportunity of attending various medical meetings. The younger men turn out in good numbers. Perhaps this is true more in the smaller communities but still at the larger meetings as well. I am sure they did not come because I was there. Many of them were not born, many were still in diapers or training pants when I started the practice of medicine. Perhaps they came to crab about the IPAC program, the polio vaccine situation or some local condition. The point is they came. They participated in the meetings, both scientific and business phases. They were working in organized medicine. I am not trying to paint any rosy picture. Attendance at medical meetings is percentage wise not high. Some were probably out chasing what our delegate for many years from Morgan County, Dr. Bowe, called "the elusive dollar." Some were playing bridge or watching TV. Enough had interest to attend the meetings. This also applies to the special societies. There the younger men show up well. Whether it be the research phase of medicine or the specialty field the intellectual stimulation for the betterment of practical ability is a decided factor. It behooves us therefore to make our more general meetings sufficiently attractive to bring these fine eager beavers to our local county society meetings. Programs such as the Scientific Work Committee has arranged for this meeting to serve as a stimulus and a challenge as well as an invitation for future annual meetings of our State Society.

Organized medicine has its science and art too. It is both internal and external. There is definite intellectual stimulation in the meeting of minds within the county or state society, the national association. Programs for advancement of medical care need approval from within. Attacks from without need keen analysis, proper defense, appropriate counterattack. Some critics say we are monopolistic in our attitude towards health issues. I disagree with that both from the intellectual and the emotional standpoint. I think of organized medicine as a collective trusteeship on health matters. The accumulated knowledge from Biblical times down to today has been given to us. It has been given to us to use for the benefit of our fellow man. Therein lies the emotional, the humanitarian phase. We are stewards. We must use our stewardship well, must give ac-

count of it to the public and to ourselves. Disclaiming this on the part of a few by self-seeking, by commercialization procedures, by internecine quarrels makes us vulnerable. I attended a meeting of an ancillary group recently. Supposedly informed lay people made some critical statements. When the medical facts were laid before them, when the public health policy procedures were explained, the whole situation was cleared up promptly and satisfactorily. A potential emotional condition became balanced by an explanation which took in both intellectual and emotional phases.

Our family group, as in all family groups, had its own particular set of phrases, almost stereotyped at times. These stayed with the family over the years. When someone in a discussion (or an argument) got away from the subject at hand the term "Mr. or Mrs. Way Far Back" usually was heard. Way far back in this paper I referred ambitiously but mistakenly to a brain storm title "A Neuropsychiatrist Looks at Organized Medicine." Being so intrigued with some of my brain children ideas I neglected the brain storm. That brings to point a comment of General Edwards, Commander of Western Base in England in World War II. He stated at a commanding officers' meeting, "If everyone who made a talk at a meeting like this was laid out end to end it would be a good thing." I am almost to the end of these remarks, which is a good thing.

I want to quote in these concluding paragraphs Dr. C. Sidney Burwell, former Dean and now Samuel A. Levine Professor of Medicine at Harvard Medical School. Dr. Burwell stated in the Harvard Medical Alumni Bulletin of January, 1956:

"The present capacity of medicine to do good is more effective than it was because of research and because the research of the last hundred years has covered a wide spectrum involving fundamental science, human physiology, and the study of the mechanisms of disease in patients. One of the needs of medical education is to maintain and to deepen the undergraduate study of the basic sciences which underlie the modern science of medicine. The indispensable discipline of the medical science is, however, not by itself enough.

"We know that in addition to the science of medicine there is also an art of healing. This art brings to the patient comfort, reassurance and a helpful degree of understanding; it lifts his courage and enlists his cooperation. The art of healing is older than the science of medicine and equally indispensable to the effective functioning of physicians."

This association of science and art so beautifully delineated by Dr. Burwell appeals to me greatly. It exemplifies the necessary combination of intellectual and emotional fields. This combination is essential to the maturity of the personality of the individual, the physician and the profession. It is something for which we all should strive. Therein lies our attainment of the achievement response which means everything to our patients and ourselves.

# Illinois Residencies in Public Health

**Roland R. Cross, M.D., Springfield**

FOR the past five years medical residencies in the special field of public health have been available to physicians of Illinois and throughout the country generally. The establishment of these residencies was a logical sequel to the formation in 1949 of the American Board of Preventive Medicine and Public Health, which now requires residency experience of candidates for certification by the Board.

Previous to the initiation of the program the American Medical Association and the American Public Health Association set up standards by which state and local health departments might be approved for the preparation of physicians for positions in public health.

Following a survey made by Dr. Haven Emerson, Professor Emeritus of Public Health, Columbia University, accreditation was given in 1951 to twelve state health departments and the New York City Health Department, involving the use of 39 local areas. Over 50 such residencies have now been established. On the initial list of local health departments approved for such training were two in Illinois: (1) the Cook County Department of Public Health, under the direction of Dr. John B. Hall; and (2) the Will County Health Department, under the direction of Dr. L. L. Fatherree.

In Illinois, the Director of the State Department of Public Health is in general charge of the public health residency program. To assist him in carrying out this responsibility the Director appointed an advisory committee to which the Illinois State Medical Society has named Dr. Tom Kirkwood of Lawrenceville as its representative.

The Illinois residencies include one year of field work as a public health resident in an accredited local health department. Arrangements are made also for the resident to attend an approved school of public health to receive a year of academic training leading to the degree of Master of Public Health. While attending the school of public health the resident receives tuition and subsistence allowances.

To date, two Illinois physicians have taken advantage of the residency program: Dr. Charles A. Lang and Dr. Albert E. Woeltjen. Dr. Lang, who has completed both the academic and field training, is now employed as Health Officer for the West District Office of the Cook County Department of Public Health, with headquarters at Maywood. Dr. Woeltjen began his residency in December, 1954, at the Cook County Department of Public Health. He is presently attending the University of Michigan where he expects to fulfill the academic requirement in June 1956.

The present policy in Illinois is to award residency appointments to qualified physicians who will accept public health positions here. In addition to being citizens of the United States, candidates must be licensed in Illinois, have graduated from an approved medical school and have completed an approved internship. A resident receives an annual salary of from $5,000 to $6,000.

One of the prime factors determining the success of a physician in public health is his ability to maintain good interpersonal, professional and public relations. Physicians interested in entering the field of public health are not required to enter a residency immediately following internship, but may begin the work even after several years of private practice. Successful experience in private practice is considered to be an additional asset for the physician entering a public health career. Physicians over 40 years of age, who have had no public health experience, are discouraged from making application.

On completion of his residency and academic training, the public health physician will readily find employment as medical director or health officer of a full-time city, county or multiple-county health department. Other opportunities

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*Director: Illinois Department of Public Health, Springfield.*

may exist in the State Department of Public Health. At times public health physicians are employed by voluntary associations, by industry, and by other governmental units. The salary is usually based on training and successful experience and is normally comparable to the average income of other specialties.

Inquiries relative to public health residency opportunities in Illinois may be addressed to the Director, State Department of Public Health, 503 State Office Building, Springfield.

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# Rehabilitation in Illinois

**Emmet F. Pearson, M.D., Springfield**

THE philosophy and practice of rehabilitation, namely, restoration, conservation, and stimulation is now well established as essential in the fulfillment of the medical arts. Doctors realizing their full responsibilities to their patients go beyond medical and surgical procedures and into psychological, social, and vocational rehabilitation problems. New impetus is being given to Rehabilitation in Illinois since the 83rd Congress greatly augmented the Office of Vocational Rehabilitation budget to encourage vocational rehabilitation of all needy disabled persons. Larger sums of State funds must be appropriated to match the Federal funds for case services over the next five years.

Illinois now has in operation two Rehabilitation Institutes providing the highest standards of team work for rehabilitation procedures. The Peoria Institute of Physical Medicine and Rehabilitation under Drs. H. Worley Kendell and Joseph Schaeffer at the St. Francis and Methodist Hospitals is a unique institution and is providing remarkably effective services for the downstate areas. The Chicago Institute of Rehabilitation, at 401 East Ohio Street, under Drs. Ben Boynton and Joseph Chivars is now getting into full operation and will in due course move into new quarters on the Northwestern University Medical campus. All general hospitals of the state carry out many of the rehabilitative procedures necessary for the majority of patients requiring these specialized services. The tuberculosis sanatoria of the state, and more recently the mental institutions of the Department of Public Welfare, are now engaged in large scale rehabilitative techniques.

For those individuals who are unable to pay for private care for rehabilitative procedures in the specialized rehabilitation institutes or in the various general hospitals there are facilities which stand ready to underwrite the necessary rehabilitation procedures within certain limitations established for their respective agencies. The University of Illinois Division of Services for Crippled Children under Dr. Herbert Kobes provides necessary services of rehabilitative nature for children up to employment age. The Illinois Division of Vocational Rehabilitation under E. C. Cline, provides services for adult disabled people whose handicap is inhibiting them in a vocational manner. The Illinois Division of Vocational Rehabilitation can purchase or provide all types of rehabilitative procedures including medical and surgical treatment, general hospital care, rehabilitation institute care, vocational training, guidance, and placement in a vocation proper for the individual. Herewith is a resume of services which can and cannot be provided by the Illinois Division of Vocational

*Medical Consultant to the Division of Vocational Rehabilitation*

Rehabilitation.

I. What we can NOT do:

1. *Employability.* We can not provide any service merely because one is disabled: there must be a *substantial vocational* handicap and reasonable expectancy that our service will result in employment.
2. *Financial Need.* We can not purchase services under II, 5-8 below unless there is proof of client's inability to pay.
3. *Duplication.* We can not provide services elsewhere available: e.g., 4c. below.
4. *Physical restoration limitations:*
   a. *Acute disabilities:* We can not treat emergencies or acute temporary disabilities such as appendicitis or pneumonia, since they are not stable, substantial vocational handicaps.
   b. *Chronic disabilities:*
      (1) We can not treat chronic disabilities medically that require only preventive or general medical care or treatment to maintain the present level of health. The prognosis must indicate a reasonable expectancy of substantial improvement in function or employability before we can help with treatment.
      (2) We can not render vocational services until a chronic ailment is diagnosed as stable, slowly progressive, or likely to be arrested in a reasonable time.
      (3) We can not render any service if chronic disability is such that employment is impossible.
   c. Those under 21 secure most physical-restoration services from the Illinois Division of Services for Crippled Children.

II. What We CAN do is to provide for the physically or mentally handicapped, preparation for employment similar to that which the public-education program provides for the non-handicapped.

The four services listed below are available *regardless of ability to pay:*

1. Complete diagnostic service — medical examinations; specialist and clinical study; psychiatric study; psychological testing.
2. Vocational counseling to develop a rehabilitation plan *with* the client.
3. Training tuition. (Amount allowed for college tuition limited to that of State schools).
4. Placement and follow-up in co-operation with employers and employment agencies.

If one is *not* financially able to provide them, these services are available:

5. Artificial appliances; hospital, medical, surgical, and out-patient psychiatric service, occupational and physical therapy, *if* diagnosis indicates:
   a. A stable physical or mental impairment, or at most, a slowly progressive one.
   b. A substantial handicap to employment.
   c. Probability of elimination or substantial reduction of the handicap within a reasonable length of time.
   d. Possible employability of the applicant.
6. Training supplies.
7. Maintenance and travel when necessary to enable client to profit from the other rehabilitation services.
8. Occupational tools, equipment and original supplies for a small business enterprise when such enterprises are feasible.

# The Treatment Of Nasal Polyposis By The Injection of Hydrocortisone

**Walter E. Owen, M.D., Peoria**

THE favorable response which ACTH and cortisone produce in various allergic manifestations has been the subject of much study and many reports in the recent literature.[1, 2, 3, 4, 5, 6] However, it has not been established that they produce any lasting or permanent benefits following their withdrawal.

Bordley and his associates [7 & 8] were the first to report the use of these hormones for the treatment of nasal polyps by local application and their results were inconclusive. They observed that the polyps became opaque and pink, began to shrink, and in some instances disappeared completely on ACTH therapy. However, following the discontinuance of this steroid the polyps recurred in two weeks to two months.

In a report on nasal allergy, Wenner[9] states that ACTH and cortisone are of value in allergic rhinitis only in nasal polyposis and that, in his experience, the results are not constant. Holley and Riser,[10] in discussing the indcations and contraindications for cortisone and ACTH, conclude that nasal allergy and nasal polyps have been favorably affected, at least temporarily.

Dill and Bolstad[11] used cortisone in a 1:4 dilution as a nasal spray 4 times daily in 25 patients with allergic rhinitis. Twelve showed marked improvement, 6 some improvement, and 7 no improvement. The cortisone spray lessened nasal secretions and decreased edema of the nasal mucosa even in patients who noted little or no relief. Many seemed to experience relief of mild asthmatic symptoms, but severe asthma was not altered. The presence or absence of eosinophiles in the nasal smear did not seem to be related to a favorable response to cortisone. The local effect of cortisone was more or less temporary; symptoms did not recur as soon after prolonged periods of therapy as after shorter treatment periods. No untoward general or local effects were noted.

These observers[12] included 10 additional cases in their second report, making a total of 35 cases of which 14 had nasal polyps. They observed only one case in which polyps disappeared and attempted no explanation for this effect. Of the 10 additional cases however, five showed definite improvement and the others had slight or doubtful improvement.

Wall and Shure[13] injected cortisone (0.1 to 1 cc. of a suspension containing 25 mg/cc.) directly into the inferior turbinates in a series of patients with various types of allergic rhinitis and with so-called vasomotor rhinitis. The 1 cc. dose caused two violent, untoward constitutional reactions, and the dose was later reduced to 0.1 to 0.2 cc. injected into alternate sides of the nose at 3-day intervals for an average of 4 injections; the decrease in dose did not appear to affect the results.

Symptoms were relieved for periods lasting from six weeks to 10 months in 42 of 52 patients with typical allergic rhinitis, but only one of the 13 patients with vasomotor rhinitis was benefited. In almost all patients, the subjective relief and the observable decrease in swelling of the nasal mucosa occurred first on the side of the nose not injected. The results were excellent in each of the patients with acute allergic rhinitis, and it is suggested that this type of treatment may keep patients with seasonal hay fever symptom-free during the entire season. Five of these patients had associated nasal polyps and all were symptomatically improved but there was no apparent effect on the polyps.

Koelsche[14] and associates treated 12 patients suffering from nasal allergy with ACTH and cortisone. All benefited as a result of therapy. Three of this group had nasal polyps, which shrunk by at least 50%.

*Presented before the Section on Eye, Ear, Nose and Throat, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

Williams[15], states that Rose and his associates observed eight patients with nasal polyps, six improved with ACTH and cortisone. In all, the mucous membrane was improved and the polyps receded or shrunk but never entirely disappeared. Adenomyxomatous polyps in the early stages may be reversible but after becoming fibrosed they may never entirely recede.

Williams[16] discusses the unfavorable effects of therapy with ACTH and cortisone. These appear to be varied. He states that Lake and Williams attempted to reduce nasal polyposis by the daily injection of 0.2 cc. cortisone acetate into all visible polyps. This treatment was carried out for two weeks without visible effect on the polyps. Commenting on the results, he concludes that nasal polyposis is essentially a collagen disease. Adenomyxomatous polyps in their early stages may be reversible but after long standing they become fibrosed and will not recede even though the allergic stimulus has been removed.

Garcia DeDios[17] believes that ACTH and cortisone modify the effect of allergic or inflammatory reactions. With the administration of these steriods, nasal polyps decrease in size or disappear but tend to recur. Also, that 100 mg/da. will relieve nasal obstruction. The consensus is that these hormones have little or no value in rhinologic conditions except on an allergic basis.

Semenov[18] presents a case report in which there was total obstruction on both sides of the nose due to polyps. He administered intranasal cortisone by injection into the septum for a period of 37 days at which time the patient had a small airway. On the 38th day, he removed all the polypoid tissue and by the 48th day the polyps returned.

In an extensive study, Evans,[19] used intranasal packs saturated with a solution of Cortogen® and Chlor-trimeton® and Cortogen intranasal drops. He concludes, in his series of 77 cases treated during the grass and ragweed seasons, that this is a valuable adjunct in the treatment of any form of nasal allergy.

Rappaport and associates [20] treated 26 ragweed sensitive patients with ACTH. Nine showed clinical improvement. Biopsy material from the inferior turbinates taken before and after treatment failed to show any change in the histological characteristics of the tissue taken which could be attributed to the hormonal therapy. In a follow-up study Rappaport and co-workers[21] using the same method of treatment, obtained a total series of 46 patients. Tissue from the inferior turbinate was obtained from 32 patients before and after treatment with ACTH. The histologic changes which took place were listed as follows: (1) An increase in the width and staining intensity of the basement membranes. (2) In patients who showed additional changes there was a tendency to a decrease in edema and an increase in staining intensity of the ground substance. (3) An increase in the staining intensity of the mature fibroblasts with the Hotchkiss method. (4) The multinucleated pleomorphic cells were increased in number and contained more granules in their cytoplasm. (5) An increase in the number of mucigen granules in the mucous glands.

Recent reports have demonstrated that hydrocortisone is more effective than cortisone, that the dosage can be reduced by one-half to two-thirds that of cortisone and the side reactions are significantly reduced.[22,23,24]

Smith[25] injected a suspension of hydrocortisone acetate into the submucosa of the inferior and middle turbinates. He concluded it was of little value in the treatment of nasal allergy. Smith also used a 2.5% suspension of hydrocortisone acetate in nasal jelly and concluded it is of value in mild cases of nasal allergy and there were no side effects or untoward reactions.

More recently hydrocortisone alcohol has been used by Silcox[26] on 174 patients. They were treated by topical application to the nasal membranes; 98 had allergic rhinitis, 57 had allergic rhinitis with polyps, and 19 had acute rhinitis. The results were on an objective basis, factors considered being color changes, reduction of tissue edema, and shrinkage or disappearance of nasal polyps. Silcox concluded that hydrocortisone alcohol exerts a potent anti-inflammatory action in allergic nasal tissue, it is effective in the reduction of nasal polyps, and that hydrocortisone with vasoconstrictors is of significant objective benefit in nasal allergies, and also provides marked subjective relief.

Hydrocortisone acetate, when injected intramuscularly, becomes an essentially inert substance. However, when hydrocortisone free alcohol is injected intramuscularly its activity is

essentially equal to that of hydrocortisone acetate which has not been injected intramuscularly. This probably accounts for the improved results which hydrocortisone free alcohol has over hydrocortisone acetate.

The histopathologic changes that occur in nasal allergy and polypoid degenerations have been thoroughly described by Hansel[27] and more recently by Semenov.[18] In general there are three structures involved; the epithelium, the basement membrane, and the tunica propria. The epithelial changes which occur are either metaplastic or degenerative in nature. There may be a change to squamous epithelium with the loss of cilia, or the epithelium may be lost entirely; on occasion both changes may be observed in the specimen. The basement membrane often is slightly thickened in allergic polyps and in other instances it may be edematous with some widening between the cellular structure. In some areas it may be entirely absent. The most marked changes occur in the tunica propria or stroma which are characterized by edema and cellular infiltration.

The edema is caused by increased capillary permeability. This takes place in the area just below the basement membrane where the capillaries are most abundant. In marked edema of long standing, the tendency toward polyp formation is greatest. The connective tissue becomes filled with fluid so that there is a widening of the intercellular spaces with the resultant effect of polyp formation. The cellular infiltration of the stroma is most abundant just below the surface epithelium. Eosinophils are the most constant and numerous cellular element. However, lymphocytes and plasma cells are commonly present in varying numbers.

It has been established that the nasal mucous membranes in allergic states and nasal polyps of allergic origin have shown improvement by the administration of ACTH and cortisone. It has also been established that there has been improvement in these conditions following the topical application of cortisone and hydrocortisone.

An attempt is made in this study to determine what value, if any, the injection of hydrocortisone free alcohol directly into the substance of nasal polyps would have in (1) the reduction of the size of the polyps and (2) the changes in the histopathologic structure of the polyps.

## MATERIAL AVAILABLE

The preparation* used in this study was Cortef.® Each cc. contains free alcohol of hydrocortisone, 50 mg. in physiological salt solution containing 4 mg. of polysorbate 80 and 5 mg. carboxymethylcellulose. Preserved with benzyl alcohol 0.9% w/v.

## METHODS USED

This suspension of hydrocortisone free alcohol was injected directly into the substance of the nasal polyps in multiple areas by means of a two inch 22 guage needle on a tuberculin syringe. Two to six injections were made in each instance, using a maximum of 0.5 cc. containing 25 mg. of material and a minimum of 0.2 cc. containing 10 mg. of material. Injections were made at intervals of 7 days. Biopsy material was obtained before the initial injection and again one week following the final injection.

## SELECTION OF PATIENTS

A total of 35 patients was selected as they presented themselves in private practice.

Group I: Five patients had no history of previous polypectomy. They had large grayish edematous polyps. Nasal smear for cytologic study revealed a predominance of eosinophils.

Group II: Eleven patients had a history of one polypectomy varying from one to five years previously. The polyps were large, edematous, and somewhat lobulated. They were grayish or grayish pink in color. Cytologic study in this group also revealed a predominance of eosinophils.

Group III: The remaining 19 patients had a history of one to four previous polypectomies. In these cases the polyps were large, edematous, definitely lobulated, and in some instances cystic. The cytology in these cases revealed a mixture of eosinophils and neutrophils.

## RESULTS

The pretreatment biopsies of the five Group I patients were essentially the same. The pathological tissue report, microscopic, "Sections reveal a typical nasal polyp showing marked edema. A moderate number of chronic inflammatory cells are present. These consist of about equal numbers of eosinophils, lymphocytes, and plasma cells."

In each case the polyps were injected with 0.5 cc. containing 25 mg. Cortef on the first visit. On the second visit, 7 days later, the polyps had

*Supplied through the courtesy of Earl Burbidge, M.D., Medical Director of the Upjohn Co., Kalamazoo, Michigan.

shrunk to approximately one-half their original size. On this visit they were again injected with 0.5 cc. containing 25 mg. Cortef. The patients were requested to return again in 7 days. On the third visit, three had no polypoid tissue remaining. They have been observed at one month, at two months, and again at four months following the second injection with no evidence of recurrence. Two of these three showed some recurrence after nine months and they were again treated as before. Four months later no polypoid tissue could be seen.

The other two patients in this group had a minimal amount of polypoid tissue remaining after the second injection. Biopsy material revealed slightly edematous tissue, covered with respiratory epithelium and few inflammatory cells. One of this group had enlargement of polyp tissue at the end of one month at which time 0.2 cc. containing 10 mg. Cortef was injected. After one week the polyp was smaller by one-third to one-half its size.

Patients in Groups II and II have been classified together because of the pretreatment histopathologic similarity of the biopsies. The differences noted were in the degree of edema, the cellular elements of the stroma, the amount of fibrous tissue present, the number of mucous glands, and the cystic formations.

The same routine of injection was carried out in all 30 of these patients. They were seen at weekly intervals and careful observation was made regarding the objective appearance of the polyps. In none did the polyps disappear entirely. Edema and size of the polyps were markedly reduced. The pale, gray, opalescent appearance was transformed into one of mild to moderate inflammation. There was no change in the size or appearance of the straw colored cystic components of the polyps. In two, an acute upper respiratory infection developed which resulted in an immediate return to the original enlargement and edema of the polyps. However, following local treatment they again receded.

Post-treatment biopsies in all cases showed a reduction in edema and cellular infiltration. There was no evidence of reduction in the amount of fibrous tissue, glandular, or cystic components which had been noted on the pretreatment biopsies Without exception in this entire series, the patients were able to breathe more easily through the nose and were improved subjectively. In no instances have untoward reactions been noted.

## SUMMARY

In reviewing the literature on the use of ACTH, cortisone, and hydrocortisone it is apparent that these hormones have a beneficial effect on various types of allergic reactions. Their local use in nasal allergies has been encouraging but not completely satisfactory. This encouragement has led to an attempt to evaluate their action on nasal polyposis.

In purely edematous tissue the effect of hydrocortisone free alcohol seems to be satisfactory, but as was anticipated it has no effect on cystic degeneration or glandular or fibrous structures. The results of 35 cases in which hydrocortisone free alcohol was injected into nasal polyps are reported.

## CONCLUSIONS

1. Hydrocortisone free alcohol can be safely injected into the nasal cavities without untoward reactions.

2. Nasal polyps of allergic origin are favorably affected by the use of hydrocortisone free alcohol.

3. Hydrocortisone free alcohol does not change the irreversible nature of cystic or fibrous tissues.

4. The only changes noted were a reduction of edema and cellular components.

5. Hormonal therapy is palliative rather than curative.

6. Indications for intranasal surgery and allergic therapy are not altered by the use of intranasal hydrocortisone.

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## Life is what you make it

About my services—the people in Bensenville entertained divided opinions. Some said they were good and others said they were not so good. I asked a friend of mine what must I do to avoid criticism. He replied, there is only one formula for your question and that is: do nothing, say nothing, amount to nothing. Those who made a success in life told me that life is what you make it. You get out of life according to what you put into it. Life is influenced by your environment, by your associates, and your willingness to use the knowledge with which you have been endowed; learn to make friends and be honest with them in all your dealings. *E. W. Marquardt, M.D. Recollections from 50 Years of Medical Practice. Read before the DuPage County Medical Society, Elmhurst, Ill.*

## Treatment of petit mal

The present paper is a report on a series of 200 patients with petit mal epilepsy treated with Milontin® over an average period of 21 weeks. Results confirm our previously published data on a smaller number of cases and show that Milontin is an effective agent for treatment of petit mal epilepsy and is relatively free from untoward side effects. No blood dyscrasias have been found to date by us or any other investigators. After five years of study with Milontin, we have come to the conclusion that it is the least toxic of all the effective drugs used in the treatment of petit mal epilepsy and, because of these qualities, should be the drug of choice in initiating treatment before more toxic drugs are used. *Frederic T. Zimmerman, M.D. Milontin in the Treatment of Epilepsy. New York J. Med. Aug.* 15, 1955.

# The Management of Ageing

**Norman B. Roberg, M.D.**
**Associate Professor of Medicine, Moderator**

**Dr. Robert J. Havighurst**
**Professor of Education**
**University of Chicago**

**Mrs. Faye Katzen**
**Jewish Family and Community Service**

**Dr. Martin Lakin**
**Research Assistant**
**Department of Psychiatry**

*Dr. Samter*: Our previous Seminar on "The Physiology of Ageing" has taught us that the fundamental nature of ageing remains to be established. In contrast to the usual pattern of progress where social awareness lags behind our technological advances, the social significance of "Geriatrics" has received increasing attention. The reasons for this reversal are obvious: The problem is right on our doorstep, and its solution is urgent. It is our intention today first to define the area of our concern; and second to examine the theoretical and practical approaches to the task ahead of us. Psychologists, social workers, and religious leaders are perhaps the first to recognize the immediacy of our needs and each has initiated remedial efforts which might form the basis for our discussion. Doctor Roberg has kindly agreed to moderate our distinguished panel.

*Dr. Roberg*: Doctor Samter has expressed the question at hand well. As an illustration of how some cultures have solved the problem of the aged, we can point to the Eskimos. When they are old and infirm, they are either exposed upon the ice or strangled with a bow string. The Swedes in some rural communities pass the farm to the oldest son when he marries. His responsibility then was to build a home for the parents and to maintain it. As in many other discussions, we must first define what ageing is. Doctor Havighurst, would you define ageing for us?

*Dr. Havighurst*: I would divide ageing into four parts. First there is the period from about 40-50 when most people begin to worry about getting older. There is no specific reason for this. It seems to be rather the accumulation of physical changes which begin to be felt during this decade of life. In general men and women become acutely aware that they have passed the peak of physical vigor and attractiveness. The next critical period comes at about the age of 55 when people become acutely aware that they are not only past the peak, but are growing older. For men there is an awareness that one is at or past the peak of his career and that the future is not indefinite for him. He has only a limited amount of time left. For women there is the growing up and often the disappearance of children, and the general feeling of having passed the period of motherhood which provided the principal satisfaction of life. Also, there is the appearance of a number of infirmities which leads people to consult a physician at about this time. The next major crisis usually occurs between 65 - 70 and is associated with retirement from work and with widowhood. Finally, there is the last major period, that of inability to manage for one's self. This does not come to all people, and of course, it does not come at the same age to people.

*Dr. Roberg*: From your comments, might one state the general definition of ageing as a loss of ability to adapt to environment?

*Dr. Havighurst*: In a sense, yes.

*Dr. Roberg*: Would you extend this in any way, Mrs. Katzen?

*Mrs. Katzen*: I would say that ageing in ad-

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**SEMINAR**
**of the**
**DEPARTMENT OF MEDICINE**
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dition involves awareness of the change not only in the physical area but in the social position of the individual as well; for example, the reversal of roles: in the beginning parents were responsible for the welfare of children — now children are responsible for parents.

*Dr. Roberg*: Mrs. Katzen's remark (and I can't resist commenting on it) reminds me of the Irish couple who adopted a Jewish baby because they had heard that Jewish children are so good to their parents.

*Mrs. Katzen*: To return to definitions, it is, of course, more than that. We also find a narrowing of the social and physical world due to death of friends and infirmities of ageing.

*Dr. Roberg*: In other words, a feeling of uselessness. Doctor Lakin, can you extend this definition?

*Dr. Lakin*: As a psychologist, I would prefer to rely upon the individual's subjective evaluation of his status. I think that the layman is rightfully impatient with the scientist's oftrepeated view that the study of ageing must begin with birth or conception. The average individual knows he is becoming old and is apt to fixate upon a definite age as a dividing line of a kind between middle and old age. Tradition has it that man's years number three score and ten. Current social usage and the individual's consciousness of himself tell him he is aged. Partly for this reason and partly because it is convenient for me, since I deal with individuals in their 70's, 80's and 90's, I think more in terms of problems of ageing which arise at those ages. Now this feeling of helplessness that Doctor Roberg mentions seems to me to be one of the psychological concomitants of the general response to the changes — physical ones, in the way society regards the individual, and in the way he comes to regard himself. We also know, however, that other undesirable personality manifestations such as feelings of inadequacy, depression, hypochondriasis, irritability, negativism, and regressive tendencies seem to have greater incidence among the aged. Even in the absence of extremes of these undesirable manifestations, there is the unfortunate fact that the aged individual frequency shares society's perception of himself as "washed up" and useless.

*Dr. Roberg*: Do you believe the management of ageing is strictly a medical problem? Should the physician be concerned with therapeutics in the usual sense, or rather with an evaluator of diminished socio-economic adaptability?

*Dr. Lakin*: Well, frankly, in the present context I do not see how else we can view the problem. That is, I visualize general practitioners seeing many older individuals in the course of their practice and I believe their treatment or advice can have greater value or meaning if they are able to take into account the special problems of the aged. Probably the doctor will be turned to very early in the game — most likely with regard to physical symptoms or manifestations. Yet, there is always the underlying aspect of the patient's feelings in regard to being old or becoming aged. It is of great importance, I think, for the doctor to be aware of, and sensitive to this aspect.

*Dr. Mark H. Lepper*: In planning for old age, the emphasis in preventive medicine is on planning at an early age. Do you believe that we have enough fundamental knowledge to do this, or even enough to give the patient advice? What should be our position as doctors with regard to this movement which seems to have so much lay appeal?

*Dr. Lakin*: It is hard to give sensible answers to Dr. Lepper's questions — mainly for two reasons. First, the patient's concern is probably a manifestation of the general social and psychological insecurity which is part of ageing. We might make him aware of the fact that we recognize the source of his apprehension, but since this is not just a superficial symptom, he will probably continue to look hopefully for a remedy supposed to cure or at least to lessen the pain and the unhappiness which is thought to be associated with ageing. The second factor is that we really do not know what constitutes the desirable retirement — the goal in retirement. I think we had better face this just as we must face the fact that we know little about many aspects of changes in psychological processes due to ageing.

*Dr. Roberg*: Do you feel that society forces older people into definite patterns?

*Mrs. Katzen*: Yes. Unfortunately, the roles assigned to older people are still very limited. Society's negative feelings toward age tend to be

incorporated by the older person himself.

*Dr. Havighurst*: Some of the problems of ageing are inevitable because of loss of individual powers, but others are produced by the society itself. The problem of retirement is largely a society-made problem. There are many individuals who remain productive well past the age of 65, and yet there is a tendency for society to define 65 as the age when all people should retire.

*Dr. Harry F. Dowling*: What methods are available to predict individual productivity in the older age group?

*Dr. Havighurst*: Unfortunately there are no reliable scientific methods for predicting productivity after the age of 65, yet I believe that a practical decision could be made in each individual case on the basis of (a) the person's own desire to work or to retire, and (b) an assessment of his usefulness by his colleagues and his supervisors.

*Dr. Roberg*: Dr. Lakin, you have done some objective investigations in the older age group. Do you have any comment?

*Dr. Lakin*: You have been discussing a somewhat younger age group. My work has been limited to the 70 and up group. Parenthetically, I would say that it is unfortunate that most of our data on the aged come from institutionalized populations. I do not have direct experience with the working aged about whom Dr. Havighurst spoke. Still, I am of the opinion that job and personal assessment methods could be very useful in aiding the appropriate placement of the older employee provided we have a good idea of the criterion, that is to say, the job he is going to be called upon to do. My own feeling is that psychological tests can be useful in a flexible employment framework where the retained productive capacity of the older worker can be effectively utilized in tasks for which he retains skills. The degree of retention of at least some of these skills is something we can investigate. Generally, there seems to be little question, but that ageing does involve loss in memory (particularly for more recent events), a lessening in motor skills and speed, some increase in difficulty in comprehension. Frequently, there is a decrease in the ability to generalize from new experiences and to deal with novel situations.

*Dr. Havighurst*: In addition there is a slow decrease in intelligence up to the age of 70.

*Dr. Roberg*: Does industry attempt to reserve easier positions for individuals as they grow older?

*Mrs. Katzen*: This has been done only to a very small degree, notably in the retail trades. To make another point, family agencies, I have found, are concerned with problems related to family relationships. It is at this level that a physician can be of great value. He is often the most trusted individual outside the family group and knows what is going on.

*Dr. Dowling*: Would you believe that it is possible to quantitate the risks of ageing so that our suggestions become less haphazard?

*Dr. Havighurst*: I doubt that with our present knowledge we can make any quantitative prediction of future productivity and efficiency of any individual man or woman at the age of 60 or 65 or 70. It is true that we could make some statistically reliable predictions which would hold for groups of people: that is, we could divide a group of 65 year old men into two subgroups, one of which would average far better than the other in its productivity over the next ten years, but there would be many individuals in each subgroup for which the prediction failed. Nevertheless, we should push ahead with research on tests of biological efficiency and we may hope for the time when the physician can make a fairly accurate estimate of the potential of the individual patient.

*Dr. Lakin*: One of the most interesting developments which needs further investigation is the apparent change in the self-concept on the part of the ageing individual. Apparently, ageing persons share the low esteem of their status which is held, in general, by our society. From some exploratory work which has been done in our laboratories as well as from other research sources, I believe that we are about to come somewhat closer to the understanding of the importance of this "shrinking self-concept" which seems to be so characteristic of this group. It is uncertain at which point or how this significant change in self-evaluation occurs, but the knowledge that it exists is pertinent to our future approach of the problem of ageing. It represents one additional factor which must be recognized by those who are concerned with its preventive or remedial aspects.

# The Dermatologist's Role in the Treatment of Skin Cancer

HENRY E. MICHELSON, M.D., MINNEAPOLIS, MINNESOTA

SKIN cancer may develop as such without any precursor but a great many such cancers do have precancerous lesions antedating the actual lesions. If all precancerous lesions were recognized and successfully treated, the prophylaxis of skin cancer would be greatly facilitated.

Debreuilh, a French dermatologist, originated the term "precancerosis" but its significance was lost because of its broad employment. Miescher, a Swiss dermatologist, has recently summarized the entire subject and has supplied a classification under three headings, based on both clinical and histologic grounds.

1. Precancerosis in a narrow sense includes circumscribed tissue changes which frequently, sooner or later, become converted into cancer:

I. Tar, X-ray, and arsenical keratoses.
II. Seborrheic and senile keratoses.
III. Cutaneous horns.
IV. Melanotic precancerous nevi (junctional nevus).
V. Verrucous circumscribed leukoplakia.
VI. Erythroplasia.
VII. Verrucae in xeroderma pigmentosum.
VIII. Bowen's disease.
IX. Paget's disease (in the clinical sense).

2. Precanceroses in a narrower sense includes diffuse tissue changes on the basis of which, in localized areas, a cancer may develop. This section proposes that a diffuse change may in certain areas become cancerous, while the entire area does not.

I. Chronic X-ray dermatitis.
II. Light affected skins (atrophy, etc.)
III. Atrophic skin in xeroderma pigmentosum.
IV. Plane leucoplakia.
V. Regressive atrophies.
   A. Kraurosis vulvae.
   B. Balanitis xerotic obliterans.

3. Possible but rare precursors of cancer:

I. Chronic infections (syphilis, tuberculosis, etc.).
II. Scars.
III. Chronic inflammations (stasis ulcer, etc.).
IV. Benign skin lesions (cysts, nevi, fibromas, etc.)

The classification here given is rather extensive, and some of the conditions listed are more potentially cancerous than others. However, the presence of the conditions listed should arouse suspicion and be carefully inspected. Usually progressive, elevated, or ulcerated lesions demand histologic examination and appropriate treatment.

There is no valid morphologic criterion for the start of malignant degeneration. Therefore, knowledge of precanceroses offers a basis for the early diagnosis and prevention of skin cancer. It also should promote cancer research and, with more knowledge a more definitive term than precancerosis will evolve.

The microscopic concept of the precanceroses has two divisions:

1. In a broad sense, cells in a stage of rest which conceivably could become cancer.
2. In a narrower sense, cells that are in a proliferative but preinvasive stage which, if the process has progressed to the point of invasion, may already be cancer.

The histologic diagnosis of a lesion which might be cancer but is not so morphologically, demands a knowledge of microscopy of the lesions previously cited and is performed best by dermatopathologists. If changes are present which may be interpreted as cancer, diagnosis is simpler, and if the dermatologist is a skilled histopathologist he has the advantage of both a clinical and microscopic interpretation. It has been my rule that if a microscopic section is strongly suggestive of cancer, it is safer to diagnose cancer and treat the patient accordingly than to take the more conservative course. The

*Presented before General Assembly, 115th Annual meeting, Illinois State Medical Society, Chicago, May 19, 1955.*

pathologists with whom I have had the privilege of associating share this view.

One might question the ability of a skin lesion to become cancerous purely on its own potentialities, for the organism as a whole must play its part. Such factors as heredity; general preparedness by way of humoral, hormonal, and cellular changes; and local disposition undoubtedly play a role, especially in internal cancer. But from a practical point of view the removal of so-called precancerous skin lesions is highly successful if done while the lesion is small. For that reason dermatologists insist on taking such small lesions seriously, for it is easier to cure a precancerous condition than an actual beginning malignancy. After cancer has become established, there is differentiation of the cells and an irreversible change in the individuality of the cell. Its functional peculiarity is lost and the regulatory influences of the surroundings are no longer able to confine the cells to their natural zone. Therefore, a lesion that may become cancerous is still in normal surroundings. One that is cancerous has, for one reason or another, exerted a deleterious effect on its surroundings.

Aside from this, the precanceroses and early cancer are quite similar, and the principles of diagnosis and treatment are about the same. With precanceroses the aim is the prevention of cancer, while with actual cancer it is early detection and treatment. I am not going to discuss types of cutaneous cancers, their location, nor their behavior, for I am more concerned with principles of diagnosis and treatment than with details.

Early diagnosis of all cancer is the wish of all. In skin cancer this can be accomplished with certainty and is within the means of all physicians. Clinical diagnoses, at best, are merely the preliminary to microscopic verification and it is my conviction that proper diagnosis and, in turn, treatment can be accomplished only if every lesion upon which a diagnosis of skin cancer has been made is subjected to biopsy. Dermatologists, particularly those who are adept in dermatopathology, have a decided advantage in evaluating a lesion when they examine it along with its surrounding area, and then do a punch biopsy. Thereafter, they choose the form of therapy. Some small lesions are excised in toto and then examined, but such lesions are in the minority. I am convinced that no clinician is astute enough to rely upon inspection diagnosis alone. I have seen so many errors in my own work that I have long since given up depending upon clinical diagnosis.

Many doctors must depend upon others for microscopic diagnoses and I must sound a word of warning. Tissue is submitted to a pathologist for diagnosis, not for suggestions on therapy. I have often seen pathologist's report which read. "The lesion is entirely excised" or some such statement. I believe this to be wrong because sections do not take in all planes of the growth and may give false assurance. Only the trained clinician who took the history, examined the patient, and has assembled all of the evidence should decide on the treatment.

The crux of all cancer work is the therapy. We hope to cure patients. This involves choosing the treatment or treatments that are best for the patient. One also must know his own limitations. He must know to what type of growth his training, experience, and equipment are suited. He must also be aware of the treatments available in other specialties. As dermatologists we have much to offer in properly selected cases. We have the ability to recognize precancerous and cancerous lesions. Most of us are able to interpret the microscopic section. If the case is a favorable one for our type of treatment we are able to carry it out without hospitalization, without anesthesia or with local anesthesia, and without any loss of time from work for the patient. This is of great economic importance. These factors being taken into consideration, I believe that the dermatologist's treatment of skin cancer is and should be the treatment of choice for a large percentage of skin cancers, but we must be the judge and remain strictly within the domain of those lesions which we have learned we can treat with a high degree of success.

It is important to determine whether the treatment to be undertaken is the primary treatment. Previous treatment obviously has been unsuccessful if further treatment is being considered. If treatment has failed, why has it failed? Was the choice incorrect for the lesion? Was it inadequate? Maybe all parts of the lesion were not reached, for outlining a growth is one of the weak links in our chain. Does the pre-

viously treated area have a good scar but with extension at the periphery? Is the previously treated area ulcerated? These are just a few of the things to consider. In the main, when treating a lesion previously treated by someone else, the approach should be exactly as though the lesion had never been treated before, which means that biopsy is called for. Secondary treatment is always more difficult and demands extra consideration, especially a change in type of treatment. Recurrences in one's own material usually are easier to evaluate but treatment still offers a greater problem than primary treatment.

The prognosis of skin cancer is dependent upon the lesion: size, location, the presence or absence of metastases, microscopic type, its response to various treatments, and the general evaluation of the patient. It must be emphasized that a patient with skin cancer may recover completely from one lesion, but a subsequent lesion in another location is a rather common occurrence.

No one who treats cancer of the skin should attempt to appraise his results without a follow-up system. Patients with skin cancer must be kept under observation for a long time.

And now a word about the psychic effect of the diagnosis of cancer upon the patient. The effect is grave on some patients; therefore, it is advisable to inform the patient and his immediate relatives just what his problem is. In basal cell cancer it is consoling to know that extension does not occur, and in the squamous cell type, metastases in most instances are easily noted and may be dealt with. Supportive psychotherapy is indicated for every cancer patient. Optimism based upon the percentage of cure should be inferred but with emphasis on the need for close co-operation and frequent examination.

It is my belief that dermatologists have contributed a great deal to the recognition of precanceroses and the early diagnosis of skin cancer and that the therapy they advocate, in the majority of cases, offers an efficient, economical, and relatively trouble-free method of dealing with the disease.

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## BCG in tuberculosis prevention

A report by the Medical Research Council published last week confirms that vaccination with BCG or vole-bacillus vaccine can prevent the clinical manifestations of tuberculous infection, particularly miliary tuberculosis and meningitis. The investigation, which involved 56,700 14 year old children living in English cities and towns, was well planned, carefully executed, and clearly reported; the results are unequivocal. It is estimated that a general vaccination scheme of children of this age should reduce tuberculous morbidity between the ages of 14 and 17 by at least half; and the more serious types of disease might be reduced even more, for in the M. R. C. investigation, meningitis or miliary tuberculosis developed in none of the vaccinated children but in six of the unvaccinated. *Editorial. BCG. Lancet, March* 3, 1956.

# Reactions During Topical Anesthesia

MAX S. SADOVE, M.D., RAYMOND F. ROSE, M. D., MYRON J. LEVIN, MD., AND EDWARD DER CAYIA, M.D., CHICAGO*

LOCAL anesthetic drugs, when administered topically, are absorbed into the blood stream and may exert a systemic as well as a local effect. This study was organized in an attempt to determine the incidence and type of reactions and procure such other data as might be obtainable. All of the cases were at the Veterans Administration Hospital, Hines, under the supervision of a committee appointed by the Chief of the Surgical Service, Dr. C. B. Puestow.

A comprehensive work sheet (Figure 1) was prepared and made available to three groups interested in this study; the Ear, Nose and Throat Department, the Thoracic Surgery Service, and the Anesthesia Department. Tetracaine (Pontocaine®) and cocaine were used for topical anesthesia, primarily for various endoscopic procedures and for endotracheal intubation prior to general anesthesia. The study extended over a two year period and charts were collected for analysis at the end of each month.

Approximately 2,100 topical anesthetic procedures were reported and work-sheets were completed adequately in about 1,700. In every case in which an adverse reaction occurred, a chart was completed adequately. In each department, the routine for the administration of topical anesthesia was continued unchanged. No attempt was made to alter existing routines or standardize procedures between the departments. Since each department utilized a somewhat different technic, it was felt that this would serve as a better method of gathering data concerning reactions.

*From the Veterans Administration Hospital, Hines, Illinois.*

*Presented before the Section on Anesthesiology, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

## INCIDENCE AND TYPE OF REACTIONS

The total number of reactions of all types

FIGURE 1
TOPICAL ANESTHETIC STUDY SHEET

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| NAME | Reg.# | Date | Age | Sex | Wt. | Ward | Physicians Signature |
| Physical Diseases | | | | | | | |
| Pre-medication (Drugs & Quantity) | | | | Route: I.M. I.V. S.C. | | Time Admin.: A.M. P.M. | |
| Topical Agent | Amount | Concentration | Time: Start APM, Stop APM | Technique: Nebulizer | Transtracheal (spray) | Applicator: Swab, Others Describe Aerosol | |
| Anesthesia: Good Fair Poor None | | | | | | | |
| Pulse: Pre-Anes. /min. | Post Anes. /min. | | Irregularities (if any) Describe: | | | | |
| Blood Pressure: Pre-Anes. /mm Hg. | Post Anes. /mm.Rg. | | | | | | |
| Respirations: Pre-Anes. /min. | Post Anes. /min. | | | | | | |
| Reaction: Yes No | | | Time of Onset APM | Duration MIN. | Severity | | |
| Type of Reaction (Check one or more that apply) | | | | | | | |
| Talkative, Nervousness, Convulsion, Recovery | Tremors, Unconsciousness, Shock, Death | | Time | Others | Describe: - | | |
| Therapy Instituted (Describe Completely) | | | | | | | |
| Review As To Cause: | Time: | Drug: | Care: | | | | |

FIGURE 2
REACTIONS IN 2100 CASES OF TOPICAL ANESTHESIA

| Type Of Reaction | Number | Ratio | % |
|---|---|---|---|
| Incidence Of Reactions Of All Types | 27 | 1 in 78 | 1.29 |
| True Reactions To Local | 18 | 1 in 117 | 0.86 |
| Exacerbation Of Asthmatic State | 2 | 1 in 1050 | 0.10 |
| Laryngospasm | 1 | 1 in 2100 | 0.05 |
| Psychomotor Reactions (Delirium tremens, simple syncope) | 2 | 1 in 1050 | 0.10 |
| Reactions To Pre-Med. | 4 | 1 in 525 | 0.19 |

was 27 in 2,100 procedures, an incidence of approximately 1 in every 78 cases, or 1.29% (Figure 2). Of the 27 reactions reported, 18 patients exhibited signs of central nervous system stimulation or depression or of vasomotor collapse, attributed directly to the topical anesthetic agent. This is a ratio of one in 117 cases, or 0.86% as the true reaction rate in this study. Three atypical reactions may have been, at least in part, due to the topical anesthetic agents. Two patients developed exacerbation of an asthmatic state and one developed repeated laryngospasm. Therefore, a total of 21 patients developed either a true or an atypical reaction to the anesthetic agent or its administration which is a reacion ratio of one in 100, or 1%. Two patients developed some form of psychomotor activity as complications and one developed an excitement delirium that was thought to be due to delirium tremens. Another developed simple syncope and four were overly depressed as a result of premedication.

Of the 18 true reactions directly attributed to the topical anesthetic agent, six were severe, eight moderate, and four were mild (Figure 3). Of the severe reactions, five showed central nervous system stimulation or depression and one exhibited a vasomotor collapse; there were four severe convulsions in this group. Of the eight moderate reactions, all showed central nervous system stimulation and depression phenomena. The four mild reactions were of the central nervous system stimulation type.

## TREATMENT OF REACTIONS AND RESULTS OF THERAPY

The mortality associated with the procedure of topical anesthesia and endoscopy was one in 2,100 cases. The fatality occurred in a moribund patient who was in imminent danger of death at the time of the endoscopic procedure. He was bronchoscoped for atelectasis following esophagectomy, and at the beginning of the procedure his B.P. was difficult to otbain at about 80 mm. Hg. and his pulse rate was 160. Shortly after the administration of 8 cc. of 1% tetracaine (Pontocaine) by spray and intratracheal instillation, the patient developed spasticity and unconsciousness which persisted for 15 minutes. amobarbital sodium (Amytal), 250 mg. was administered intravenously in an attempt to treat the hypertonic activity. Oxygen, intravenous fluids, and general supportive therapy also were utilized. The patient remained in a depressed state until his death approximately 28 hours later. It is highly probable that the amount of tetracaine (Pontocaine) given this patient was unnecessary as well as excessive. It also is questionable whether or not this contributed to his eventual demise. Since a reaction occurred necessitating treatment with a barbiturate, both the reaction and the barbiturate were further depressant to a patient already in a moribund state.

The remaining five patients with severe reactions responded in from five to 30 minutes, with no sequelae. They were given oxygen, intravenous fluids, repeated small doses of barbiturates just sufficient to control convulsions, and vasopressors to control vasomotor symptoms when indicated. Treatment of the moderate reactions consisted principally of the administration of oxygen and

FIGURE 3
TRUE REACTIONS TO TOPICAL ANESTHETICS

| Severity | Number | Cns Stim. & Depr. | Convulsions | Vasomotor Collapse | Compl. Rec. | Deaths |
|---|---|---|---|---|---|---|
| Severe | 6 | 5 | 4 | 1 | 5 | 1 |
| Moderate | 8 | 8 | 0 | 0 | 8 | 0 |
| Mild | 4 | 4 | 0 | 0 | 4 | 0 |
| Total | 18 | 17 | 4 | 1 | 17 | 1 |

small doses of barbiturates. The patients exhibiting mild reactions required no treatment other than observation.

In four patients with severe reactions, and in one with a mild reaction, the endoscopic procedure was not carried out. In the remaining cases, the endoscopic or other operative procedure was successfully completed after the reaction was under control.

Of the patients exhibiting atypical reactions, two developed a marked increase in their asthmatic state, preventing completion of the procedure. In both cases pentobarbital (Nembutal®) and codeine had been given as premedication and routine doses of tetracaine (Pontocaine) were used. In one patient exacerbation occurred prior to completion of the administration of the topical anesthetic agent. Both of the patients responded to oxygen and epinephrine and there were no sequelae. One patient had repeated laryngospasms, once following topical anesthesia preliminary to tonsillectomy and twice after infiltration of lidocaine (Xylocaine®) solution for tonsillectomy the same day. Recovery was prompt and uneventful after aspiration of secretions, administration of oxygen by mask, and assisted respiration.

In the two patients who developed some form of psychomotor activity, one developed an excitement delirium prior to the administration of the topical anesthetic agent. He was returned to his room for treatment of delirium tremens. Another patient developed a simple syncope at the onset of the anesthetic procedure, which necessitated only a change of posture and a slight delay. Subsequently the usual topical anesthesia and endoscopic procedure were carried out uneventfully.

Premedication varied, but the majority of patients were given a barbiturate plus morphine and atropine. In general the patients were given 100 to 200 mg. of pentobarbital (Nembutal) orally, and 10 to 15 mg. of morphine, with 0.4 mg. of atropine hypodermically. In this study, four patients were thought to be overly depressed as a result of excessive premedication. Three of these patients were debilitated and it would probably have been wiser to diminish the total dosage and eliminate morphine. In two patients, although they were severely depressed mentally, respiration and circulation were adequate. Besides the marked psychic depression, one patient had hypotension and another patient was pale and perspiring profusely. Treatment consisted of maintenance of an adequate airway, administration of oxygen in one case, and intravenous nalorphine (5 mg.) in another. In two overly depressed patients, the topical anesthetic was given and the operative procedure carried out uneventfully after a delay.

## DOSAGE AND RATE OF ADMINISTRATION

In this study, adverse reactions to any single drug technic occurred with approximately equal frequency throughout the various dosage ranges. One might get the impression that the total dose of the topical anesthetic agent was of relatively little importance. To a degree this may be true, but its loose interpretation is dangerous. Unfortunately, in many instances the total dose recorded was only a clinical estimate and the rate of administration was ignored. The primary factor would seem to be susceptibility of the individual compared to the blood level at a particular moment. The concentration and the total volume of the agent used is certainly a factor in determining the blood level of a drug and its concentration in tissues such as brain and heart. The rate of administration, however, seems to have been ignored or not given its true place in the incidence of reactions to local anesthetic agents. From this study it would seem that time is a much greater factor in blood level concentrations and the level in reactive tissues than was previously understood. In the group in which tetracaine (Pontocaine) was used alone there were 18 reactions in approximately 900 cases or an

FIGURE 4
Reactions Due To Topical Anesthetic Agent According To The Drug Used

| Drug | Approximate number of cases | Reactions due to the topical Agent | % |
|---|---|---|---|
| Pontocaine | 900 | 18 | 2.00 |
| Cocaine | 100 | 2 | 2.00 |
| Cocaine-Pontocaine* | 730 | 1 | 0.14 |

*In this series, 4 patients were overly depressed by premedication, and the rate of administration was more carefully controlled.

incidence of 2%. In approximately 100 cases in which cocaine alone was used, there were two reactions or an incidence of 2% (Figure 4).

In a group of approximately 730 patients, there was only one reaction. The technic in this group consisted of 2 cc. of 1% tetracaine (Pontocaine) and a maximum of 2 cc. of 10% cocaine by instillation through the larynx into the trachea. On superficial examination, it would seem that this method was much safer and one could erroneously conclude that the cocaine-tetracaine (Pontocaine) mixture is superior. In this group, however, the rate of administration was carefully controlled by utilizing the clock and administering small amounts at regular intervals. A minimum of 10 minutes was required and rarely was the entire dose completed within the 10 minute period. No opinion is expressed as to whether or not cocaine is safer than tetracaine (Pontocaine) but it must be pointed out that statistically this technic was significantly safer than the routine technic of using variable quantities over a variable period of time. It was in this same group, however, that four patients were overly depressed as a reaction to their premedication. It is somewhat frightening to notice the rather heavy premedication, but this may have been a factor in reducing the incidence of reactions.

## DISCUSSION

A thorough and careful history should be obtained prior to the use of any local or topical anesthetic agent. A history of fainting or of previous reactions to any of these drugs must be noted and extreme caution used in these patients. A previous reaction, syncope, or psychomotor phenomenon would tend to repeat itself in a specific individual.

Proper psychic and psychological management is important in any patient undergoing a procedure of this sort. Since most patients are frightened by the procedure, kindness, understanding, and reassurance must be utilized in preparing the patient and during the procedure as well. This tends to diminish the psychomotor reactions or even the asthmatic attacks and may be as important as premedication itself.

This study did not confirm nor disprove the belief that barbiturates protect against reactions. Some form of sedation, however, is justifiable as premedication. Each patient is entitled to a reasonable degree of sedation during an endoscopic procedure. It can be shown pharmacologically that it is wiser to protect against reactions than to wait for a reaction and treat it with the barbiturates. The use of drugs in a routine manner, however, is to be condemned. The dose of the sedative should be based on the actual need of the patient, considering such factors as weight, excitability, metabolic activity, and disease states. Care and caution should be used in the administration of depressant drugs since the use of excessive doses adds little to the protection of the patient and may even increase the hazard should a reaction occur. Since the oral administration of the barbiturates is not as reliable as intramuscular injection, the latter route is preferred for their use as premedication. The barbiturates should be given intramuscularly approximately two hours prior to the beginning of the procedure. Their maximum effect should have occurred prior to the administration of the topical anesthetic agent. Little harm will result from giving the proper dose of these drugs even three or three and one-half hours prior to the procedure. The patient still would have adequate sedation for relaxation prior to the procedure.

The routine use of morphine or its substitutes as part of premedication is questionable. It is to be feared that if morphine is given at a time close to the endoscopic procedure, the narcotic and the barbiturate may have a synergistic effect and depress the patient too much. The hazard of vomiting and aspiration by the overly depressed patient following the procedure also must be considered. The antitussive action of morphine may or may not be desirable, depending upon the endoscopic procedure. Also, morphine tends to increase bronchoconstrictor tone, although there is debate as to whether or not this occurs with small or large doses as well as the degree to which it occurs. It would seem, therefore, that morphine should be avoided in those patients having bronchospastic states or respiratory difficulty. Indications for narcotics should exist rather than administering them routinely. The primary indication is relief of pain. If pain is a problem, one of the newer synthetic narcotics such as Meperidine (Demerol) or alphaprodine (Nisentil®) may be the drug of choice rather than morphine.

An indication should exist also for the use of

atropine and scopolamine, based upon the use of narcotics or the physiologic needs of the patient. Otherwise they should be omitted. Their primary physiologic use would seem to be control of troublesome secretions in procedures such as laryngoscopy. Following preparation and premedication these patients should be watched carefully for the hazards which heavy premedication entails. They should not be carelessly wheeled to the endoscopy room in a chair, but should be treated the same as patients having any other major surgical procedure. They should be watched for pallor, tachycardia, respiratory depression, or other signs of vasomotor or central nervous system depression. If any of these phenomena occur, proper resuscitative therapy should be instituted, the procedure should be cancelled until a later date, utilizing smaller doses of premedication. In the patient who is overly depressed as a result of a narcotic, the use of nalorphine (Nalline) as a specific antidote must be considered.

With regard to the technic of administration, there has been much debate as to whether or not the applicator or the spray is superior but this is of relatively little importance. It is the rate and degree of absorption that determines the blood level of the local anesthetic agent, and its concentration in the effector organ. Anything that increases the rate and degree of absorption such as concentration, volume, rate of administration, or inflammation of tissues, increases the incidence of reactions. In the administration of local anesthetic agents, not only concentration and total dosage, but the rate of administration should be carefully controlled. In the past, time has been used with extreme liberality and estimates of total dosage have been nothing more than rough estimates. The atomizers, nebulizers, and containers used have not been graduated so as to measure the amount administered with sufficient accuracy. The equipment should permit accurate measurement of the amount of topical anesthetic agent used to within 0.25 cc. The concentration, the total volume, and the total time should be decided upon before the procedure is started. These factors will be determined by the condition of the patient, the procedure to be done, and the reaction of the patient to the procedure. The total dosage should be proportioned over the total period of time so that the agent is administered slowly and in small increments.

For example, if 5 cc. are to be given in 10 minutes, only 0.5 cc. should be administered in any one minute period, checking with watch or clock. The equipment should be such that only a small measured amount can be given without refilling. Only in this way can dosage and rate of administration be controlled. The addition of vasoconstrictor drugs to the local anesthetic agent was not studied in this series. A study of this sort should be undertaken to determine whether or not it would diminish reactions.

A topical anesthetic agent never should be administered without having at hand resuscitative equipment and drugs. A thorough knowledge of the reactions and how to manage them is essential. The moment the least evidence of central nervous system stimulation such as nervousness, talkativeness, fright, tachycardia, or tremor, appears be prepared for a reaction. Reassurance, calmness, kindness, and a careful approach to the patient must be utilized. Equipment for the administration of oxygen, artificial respiration, maintenance of circulation, control of central nervous system stimulation, and intravenous therapy must be at hand. A high percentage of reactions require little more than sedation and oxygen. The routine use of barbiturates in careless dosage is to be condemned. Minimal doses of barbiturates should be the rule rather than the exception.

The drug of preference is a short acting barbiturate used in dilute concentration and administered intravenously. The amount must be the minimum necessary to prevent severe convulsions and to get an adequate respiratory exchange. Remember that reaction to a local anesthetic agent may be depression as well as stimulation of the central nervous system and that both may occur simultaneously at different levels. Also, depression may follow stimulation resulting from a reaction. In such cases, if the depression due to the barbiturates is added to the depression from the reaction, the patient may be in a precarious state. The patient's blood pressure must be watched and maintained at a safe level through intravenous infusions and, if necessary, vasopressors. The type of vasopressor must be carefully chosen since the central nervous system stimulating effect of many vasopressors may potentiate the reaction to the local anesthetic drug. Also, many of the vasopressors have a

direct effect upon the myocardium and this must be taken into consideration when they are used. The analeptics such as caffeine, nikethamide (Coramine®), or pentylenetrazol (Metrazol®) have no place in the treatment of reactions to local anesthetic drugs. Stimulation of the central nervous system at the sites at which these drugs usually exert their effect is undesirable.

The asthmatic patient is a real problem in procedures of this type. Since the barbiturates as a group are vagomimetic in action, there has been much discussion as to whether or not they may have some harmful effect. It never has been fully decided as to which barbiturate produces the least vagotonia, but it is the general impression that they have a vagomimetic action, dominantly present in the shorter acting groups. Since morphine tends to increase bronchoconstrictor tone, it may be a hazardous drug in the asthmatic patient. Meperidine (Demerol) would seem to be safer for the asthmatic who is having pain. Prior to the procedure the therapy which the patient has been using should be investigated as well as what drug is most effective in relieving his asthmatic state. Bronchodilators may be given prophylactically. At the time of the procedure, the drug which has been most effective in that particular patient should be available. Many endoscopists have warned against the use of Pontocaine in this type of patient and a great number of them prefer to use cocaine. We are still somewhat frightened by the use of Pontocaine in these patients, but we have no proof at this time that cocaine is superior.


## SUMMARY

A series of 2,100 cases of topical anesthesia were observed over a two year period, with a total of 27 adverse reactions. There were 18 patients with true reaction to the local anesthetic, or an incidence of approximately one in 117 cases. In this study there was one death in a patient who was moribund at the time the procedure was begun. Three patients had atypical reactions attributable to the local anesthetic agent, two had exacerbation of their asthmatic state, and one had repeated laryngospasms. Two developed some form of psychomotor activity and four were overly depressed as a result of excessive premedication. With the exception of the one death, all of the patients made uneventful recoveries with no sequelae.

It is felt that the proper use of topical anesthetic agents prior to endoscopic procedures requires thorough evaluation and preparation of the patient preoperatively. Special problems concerning the patient and psychological preparation are important. Premedication should be tailored to suit the individual patient. The administration of the topical anesthetic agent should be carefully conrolled and the patient watched closely at all times. Be prepared to manage any emergency which might arise. A thorough knowledge of the systemic effect of local anesthetic agents, the types of reactions, and the proper management of the reaction is essential. The problem is primarily one of maintenance of oxygenation and circulation without either overly depressing or stimulating the patient. By far the greatest majority of reactions, if recognized early and treated properly, will subside promptly and leave no sequelae.

# EDITORIALS

## Dr. Stone inducted into Presidency of State Society

At the closing session of the House of Delegates in its 1956 Annual Meeting, Dr. F. Lee Stone of Chicago was inducted into the office of president by his predecessor, Dr. F. Garm Norbury of Jacksonville.

Dr. Stone, who resides at 14 West Elm Street, Chicago, was born in St. Louis, January 4, 1885. His family moved to Byron, Ill., then to Chicago.

He was graduated from the University of Illinois College of Medicine in 1910. After an internship of two years at Cook County Hospital, he began to practice at Beaver Crossing, Neb. In 1914, he returned to Chicago to prepare for a career in obstetrics and gynecology. He later became an instructor in that specialty at the University of Illinois College of Medicine, and now retains the title of associate professor (emeritus) at the medical school.

For the last 42 years, he has been associated with the Henrotin Hospital, Chicago. He has been senior gynecologist there since 1941.

Dr. Stone served as a captain in the Army Medical Corps in France during World War I. He is a Mason, Shriner and Rotarian. He is married and has two sons, Dr. Robert G. and Frank L., Jr., the latter in the armed forces, and a daughter, Mrs. Arthur Kuss of Chicago.

His office is at 30 North Michigan Avenue, Chicago.

## The patient worries

Persistent hoarseness is the most common symptom of cancer of the larynx. This fact is mentioned in every textbook of medicine and surgery and on every cancer detection leaflet that goes to physicians and the laity. But the following letter, which was sent to the editor of a large Chicago newspaper, speaks for itself:

"For several years laymen have been barraged with magazine and newspaper articles, pamphlets, films, word-of-mouth 'talk-talk,' regarding the early detection of cancer by consultation with 'your family physician.'

"About a year ago my husband's voice became hoarse. He assumed it to be laryngitis, as the result of a cold coupled with his work in a terrifically dusty asphalt plant. In mid-July, because of an electrical flash burn which seared his face, ears, eyes, hands, and arms, he was hospitalized in a strange town with a strange doctor in attendance. Visiting him at the hospital, I requested this doctor to check the hoarseness. He, apparently assuming the hoarseness was the result of the burn, did authorize an X-ray. The X-ray was 'negative,' he said. His only advice (he made no throat examination) was 'quit smoking so much.' Hoarseness continued.

"On two occasions in August and September, my husband saw our family doctor. We had confidence in this man, though admittedly our physical woes up to then had been limited to minor flu bouts, tonsillitis, and a sebaceous cyst.

His diagnosis, 'chronic laryngitis;' his advice, 'don't smoke so much;' his prescription — the inhalation of medicated steam, along with pills to combat a supposed allergy to dust. Hoarseness continued.

"Early in November we hit the jack-pot. By-passing the family physician, we consulted a throat specialist. Right quick! Hospitalization — biopsy — double-checked pathologists' (2) reports: 'vocal cord — epithelioma — squamous tissue — 2nd grade.'

"A sad day for us. Two out of three physicians not sufficiently 'suspicious' to check a much-publicized symptom of cancer."

The effect of this type of publicity is obvious. It nullifies the good effects of 100 newspaper articles dealing with progress in medicine and the wonderful things done by the family physicians. Many medicos do not realize that good public relations begins in the office and that the public measures us by what we do, rather than what we get others to say about us.

A patient with cancer walks a one-way street until the disease is detected. There are two sides to every question but it is difficult to miss when the indications are clear and there is only one way to make the diagnosis. When hoarseness persists longer than three weeks a laryngoscopic examination should be advised.

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## Good nutrition required for aged

Good nutrition will slow the aging process and make it possible to live longer and grow old more comfortably, according to Dr. Max Millman of Springfield, Mass., writing in the A.M.A.'s Today's Health.

However, there are problems in the aged, the most common reason for malnutrition being "rigidity of their eating habits," Dr. Millman said.

Decayed or missing teeth or ill-fitting dentures contribute to the difficulty by forcing oldsters to exclude all solids from their menus. They take to diets of soft, mushy and soupy food. The remedy, he said, is quite simple: Correction of the dental problems.

Money is another factor. The aged who have to get along on shrunken budgets often feel that meat, fruits and vegetables are too expensive. So, they turn to starches which are cheaper and easier to obtain, prepare and eat. A better knowledge of food values and cost, coupled with proper marketing and budgeting, can insure an adequate diet on a modest income.

Malnutrition usually suggests underweight, but sometimes it is masked by overweight. Obesity in the aged often proves disabling as well as predisposing its victims to diabetes, high blood pressure and heart disease. Reducing is more difficult because eating habits have become rigid.

According to the Food and Nutrition Board of the National Research Council, a man of 65 requires 600 calories a day less than the 2,400 to 3,000 required at 25. In women, the difference is 500 calories, or 1,500 to 1,900 daily.

Dr. Millman suggested that the daily diet of the aged include one pint of milk; butter or margarine fortified with vitamin A; peanut butter or other vitamin rich fats; one serving each of oranges, grapefruits or tomatoes; green or yellow vegetables; potatoes or other vegetable or fruit; whole grain cereal; eggs; meat, poultry or sea food; and enriched or whole grain bread. The diet should contain ample protein.

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## Illinois mental hospitals commended

Physicians in Illinois have noticed with pride the gradual betterment in the care of the mentally ill confined to state hospitals. Many of the improvements in facilities and care have occurred in the last 3 1/2 years under the administration of Dr. Otto Bettag, who was appointed director of the State Department of Public Welfare in January 1953.

This was recognized at the recent eighth annual Illinois Mental Health dinner. Dr. Francis J. Braceland, president of the American Psychiatric Association, described present Illinois care of the mentally ill as "enlightened" but he referred to hospitals in many other states as "sad travesties of medical art and science and an unflattering reflection of the culture which fashions and peoples them indifferently."

Dr. Braceland said "unless mental hospitals are made into therapeutic communities; unless they are properly staffed and provided with adequate personnel in all service categories; unless they are centers of education, training and research, they will never be healing institutions in the true sense of the word." He characterized the Illinois mental health effort as "remarkable"

in view of the fact that admissions to Illinois state mental hospitals are now declining, which is contrary to the national trend.

Dr. Braceland stated that nation-wide, the cost of mental health services is now excess of one and one half billion dollars annually, and is rising at the rate of $100 million each year, with no perceptible leveling off in most places.

He commended Illinois for the multi-million dollar state financed research program now in progress. He called for vastly expanded research programs throughout the nation, with teams of research workers attacking the problems of mental illness along all possible avenues.

Governor William G. Stratton, honorary chairman of Illinois Mental Health Week observance, gave a brief greeting to the large group assembled. Dr. Bettag was toastmaster.

Dr. Bettag has been an active member of the Illinois State Medical Society for many years, and he, with Dr. Roland R. Cross, director of the State Department of Health are regular attendants at the meetings of the State Society's Council. Both directors gave interesting reports at these meetings, telling of the many things which are being done in Illinois to improve the general health and to care for the mentally afflicted.

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## Dr. Coggeshall honored

Dr. Lowell T. Coggeshall, dean of the Division of Biological Sciences, including the School of Medicine, of the University of Chicago, was the honored guest at a reception and dinner sponsored by the Chicago Medical Society at the Drake Hotel, Chicago, April 28. Dr. Coggeshall was recently appointed by President Eisenhower as special assistant to the Secretary of Health, Education and Welfare.

Tribute was paid by the Chicago Medical Society to Dr. Coggeshall by his many friends assembled to greet him on this occasion. Dr. Maurice M. Hoeltgen, president of the Chicago Medical Society, presided.

Dr. Coggeshall has been dean since 1947. Prior to that, he was chairman of the Department of Medicine at the University.

He has long been a member of the Illinois State Medical Society and is well known by thousands of Illinois physicians, all of whom join in offering congratulations and best wishes to him in his new position. He has been generally considered as one of the nation's leading medical educators, and has become well known throughout the country for his work in tropical and infectious diseases.

Dr. Coggeshall was granted a leave of absence to assume the important position in the Department of Health, Education and Welfare.

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## Psychiatric nursing

The fifth Affiliate School of Psychiatric Nursing in the Illinois Department of Public Welfare was opened on March 12, at Anna State Hospital. This school has a capacity of 50 students. The five Affiliate Schools of Psychiatric Nursing now provide three month training courses in psychiatric nursing for approximately 1,500 nurses annually. Facilities now are adequate to permit all Illinois student nurses to receive the required psychiatric nurses' training within the state.

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## New secretary of A.M.A. Industrial Health Council

The Board of Trustees of the American Medical Association has appointed Dr. B. Dixon Holland as secretary of the A.M.A. Council on Industrial Health.

Dr. Holland, who succeeds the late Dr. Carl M. Peterson, soon will retire as a colonel in the U.S. Army Medical Corps and will fill the new post about July 15.

A native of Denton, Tex., Dr. Holland was graduated from the University of Texas Medical School, Galveston, in 1934.

Dr. Peterson died September 27, 1955, as the result of an airplane accident. He held the position with the A.M.A. for about 25 years. During this time, he was an active member of the Illinois State Medical Society and for a number of years was a member of the Society's Committee on Industrial Health.

# MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

# The Evolution And Function of A Tissue Committee

WILLIAM REQUARTH, M.D., DECATUR

AN important element in hospital staff organization in recent years has been the Tissue Committee, a group composed of staff members which evaluates the quality of surgical care. Because of increasing interest in this hospital staff activity, we wish to outline the evolution and growing pains of such a committee in a 350 bed general hospital.

At this hospital, the Tissue Committee is appointed annually by the Chief of Staff. The first committee formed consisted of five department heads but later experience demonstrated that there was better function when the committee had a wider representation from the staff. At present it has eight members. In addition to representation from the field of general practice, the various surgical specialities, especially general surgery and gynecology, are represented. Members are selected on the basis that they can judge performance of their colleagues. The most important figure in the proper function of such a committee is an able and completely honest pathologist. He acts as ex-officio member of the committee but in an advisory capacity only. It is important that he be separated from any part in committee decisions on an individual case.

At the start, all surgical operations were reviewed but because of time limitations, certain types of surgery are now omitted, such as those for hernia, hemorrhoids, and tonsils. Although this is not strictly fair, it shortens the committee work and gives the desired result since it appears that the chief source of unnecessary surgery lies in appendectomies and operations on the female reproductive organs.

The activity of the committee is centered around the Medical Record Librarian who reviews the surgical lists from month to month and selects cases to be reviewed. Cases selected are those in which (a) a normal organ was removed; (b) there is a notable discrepancy between preoperative diagnosis and pathologic diagnosis; and (c) no tissue was removed on exploration.

Prior to the regular meeting of the Tissue Committee, these charts are distributed to members of the committee for a pre-meeting review. If the operation appears to be justified, for example vaginal hysterectomy for prolapse with removal of a normal uterus, the chart is approved by the member and put back in the files. If there is a question about disposition of the case, the chart is held for review by the entire committee at its meeting. At the time of the meeting the member who reviewed the chart presents a resumé before the committee.

Meetings are held only when necessary and not on a regular basis. The system of pre-meet-

ing reviews of the records has cut down the work load of the committee to the extent that meetings are necessary only every two to three months, whereas in the beginning they were held as often, as every two or three weeks. During the discussion of an individual case it is important that other members of the committee not know the name of the operating surgeon. If the indications for surgery are not substantiated by the history the case is classed Category B (unjustified) and a brief note is written giving the reason for the committee action.

The Medical Record Librarian keeps a separate "performance" card for every operating surgeon, identified only by a code number and not the name of the surgeon. On this card is kept the total number of operations in the various categories with the number and percentage of those considered unjustified. The master code with the surgeon's name and assigned number is known only to the Record Librarian. At approximately yearly intervals activities of the Tissue Committee are reported to the regular Medical Staff at which time the various operating surgeons can go to the Record Library and examine their cards.

The appraisal of appendectomy is somewhat different. In the early days of the committee each case in which a normal appendix had been removed was considered individually on its merits and a decision rendered as to whether surgery was justified. Because of the large number of appendectomies and the frequent differences in opinion among committee members as to justification another method was devised which appears to be better. The operation of appendectomy is handled purely on a statistical basis. Patients admitted to the hospital with a diagnosis of acute appendicitis and who submit to appendectomy constitute the total group. If a normal appendix is removed, regardless of clinical findings, it is automatically classified as unjustified. Assuming that all surgeons will remove a certain number of normal appendices. under this arrangement it is not the number that is removed but the percentage in relation to the total number of appendectomies on his card. In this hospital at present 15% of appendectomies done for acute appendicitis will result in the removal of a normal appendix.

We are fortunate to have a co-operative staff and the Tissue Committee is looked upon with favor by most members. There has been criticism but it has been constructive criticism. There was extreme objection to the term "unjustified" and it is no longer used. Patients are now classified as Category A (justified) or Category B (unjustified). Originally, the surgeon's name was put at the top of his own card and these cards were presumably in the sole possession of the Medical Record Librarian. Following staff objections a code number was substituted for the surgeon's name.

Staff members are given an opportunity to appear before the committee to justify cases which have been put in Category B. A busy surgeon with a large volume of work may have one or more category B cases, but since it is a small percentage of the total he may not choose to appear before the Committee. Where the performance record of a surgeon is significantly higher percentage wise than that of the hospital average, the Executive Committee is notified. Recommendations for disciplinary action are made solely to the Executive Committee of the hospital, the Tissue Committee having no part other than pointing out the deficiency. It is unlikely that Executive Committee action would ever be recommended on the basis of only one or two cases. It is important that it be kept in terms of statistics or percentages and never individual cases.

*TABLE I*

| Category B operations | | | |
|---|---|---|---|
| Percentage of | 1952-53 | 1953-54 | 1954-55 |
| Appendix | 30.5% | 20.5% | 15.1% |
| General surgery | 2.4% | 1.2% | 1.3% |
| Pelvic operations | 21.1% | 15.9% | 4.4% |

The accompanying table indicates the progressive decrease in Category B cases in the past three years in this hospital. The greatest improvement has been in pelvic procedures where the percentage dropped from 21% to 4%. The percentage of Category B appendectomies is 15% which we believe is probably the correct percentage of diagnostic error for capable, conscientious surgeons treating suspected appendicitis.

The Tissue Committee is merely one step toward the ultimate goal of complete medical audit since there is no logical reason why sur-

gery should be selected to the exclusion of all other fields of medicine. The Committee has materially increased the caliber and standard of surgical care in this hospital. Disciplinary action has never been necessary against a member. Confronted with the data on a statistical basis plus a comparison of their performance in relation to their colleagues has been all that is necessary to improve an individual surgeon's performance.

The question has arisen that such classification of surgical cases might result in malpractice suits. This appears highly unlikely and moreover, a surgeon should stand on his work and even if judged deficient by his colleagues should still be able to defend it. There is no question that a functioning Tissue Committee raises the standards of surgical care.

(Other committee chairmen in this period have been Drs. V. L. Long, A. C. Simon and J. B. Waller.)

## 1956 A.M.A. medical directory completed

The 19th edition of the American Medical Association Directory has been completed. Deliveries are being made to subscribers.

This is good news for thousands of medical societies and many others throughout the nation, as the previous edition was published in 1950. This huge book has required 20 months of work.

The new edition contains 3,122 pages, and lists information on 240,638 physicians in the United States, its dependencies and Canada. It also lists American graduates temporarily located in foreign countries. Since the 1950 edition of the Directory was published, more than a quarter millon changes of address have been recorded in the files of the A.M.A. Directory-Biographical Department; 46,348 names have been added, 24,225 have been deleted because of death and 1,172 deleted for other reasons.

In the new Directory, an increase of 16,784 physicians is noted over the number reported in 1950. This represents an average yearly gain for the past six years of 2,797. For Canada, the 1956 Directory lists 17,906 physicians, a rise of 3,310 over the 1950 total, or an annual increase of 551. No other book gives the information relative to the medical profession that is found in the 1956 Directory.

The price is $30.00, including postage, within the United States. Orders may be placed by writing to Philip E. Mohr, editor of the Directory, American Medical Association, 535 North Dearborn street, Chicago 10, Illinois.

## Aging unit in Institute of Health

Programs of the National Institutes of Health have been consistently expanded and the 1957 budget calls for a 28 per cent increase over the previous year in funds available for research. To the specialized research of the Gerontology Section of the Heart Institute has been added a special aging unit in the Institute of Mental Health. *Editorial. Federal Activities in Aging. Geriatrics, March* 1956.

# THE P. R. PAGE



At least 23 full-length medical science stories are published each month by more than 50 of the nation's leading magazines — those with a circulation of 1,000,000 or more — AMA's Press Relations Director John L. Bach reported at a recent medical public relations meeting.

A Look magazine survey disclosed that in 1923 American magazines published a total of 30 stories on four medical subjects — cancer, tuberculosis, heart disease and polio. Just 30 years later, in 1953, there were 299 articles on the same four subjects in mass-circulation periodicals.

Mr. Bach attributed the public's heavy appetite for medical science news to "two main urges of the human mind — the urge to live and the urge to know."

"The medical science writer's reporting has had a commendable effect in inspiring public confidence in the medical profession," he said. "The outpouring of facts, opinion, information and instruction in newspapers and magazines has been a powerful force in acquainting the public with the problems of practicing physicians.

"The accredited science writer, through his articles, has given much practical help to many readers. Through him, a patient who may have lost all hope is given renewed hope and finds a physician who can help him. This points up the good in accurate science reporting."

At the same time, Mr. Bach pointed out, the avalanche of medical publicity, much of it glamorized, is raising new problems between physicians and their patients.

"While the publicity itself has built up in the public mind a high regard for the advancement of medical science," he said, "the word 'science' now carries some connotation of magic in the non-scientific man's vocabularly.

"So much has been written on what's new in medical science and what science reveals that it is not easy for the man-in-the street to understand where science leaves off and science fiction begins. His science fiction expectations are becoming attached to his doctor, who is the only real live scientist he knows — a dispenser of wonder drugs and a performer of life-saving operations. That's what the public has been reading.

"With this present-day attitude on the part of the patients, doctors are having a hard time adjusting themselves to this condition. The heavy publicity is creating conflicts in the physician's attitude toward his practice and in relationships with his patients. He thinks that in order to keep his patients' confidence he must live up to a superhuman role, and build the illusion that medicine is an exact science and doctors are infallible."

The A.M.A. spokesman also pointed out that considering the many hazards a doctor faces in his daily practice, the public relations of the profession as a whole are better today than those of any other profession.

"Since a physician is the only professional man who deals with life, he is the most vulnerable to attack," Mr. Bach said. "His public relations, for good or bad, are at stake from the time he gets up in the morning until he goes to bed at night. Nearly every decision he makes carries an element of hazard. Everything a doctor does has a potential good or harm to the patient.

"Drugs often work wonders, but sometimes they have adverse and even fatal effects. The doctor must be aware of the risk every time he picks up a pen to write a prescription. If something goes wrong, the doctor's public relations suffer.

"Public understanding and appreciation of these and many other hazards is needed to help the doctor avoid unfair criticism."

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## Clues to suicide

Three-fourths of our subjects who committed suicide had previously threatened or attempted to take their own lives. This means that suicidal behavior, whether attempted or threatened, must be taken seriously, as the next suicidal gesture may be the final one. Almost half of the individuals who committed suicide did so within three months of having passed an emotional crisis and after they seemed on the way to recovery. This means that physicians and relatives must be especially cautious and watchful for at least 90 days after a person who has been suicidal appears to be improving. On the basis of comparisons among psychological tests, it appears that the person who threatens suicide seems to be more emotionally disturbed than the person who attempts suicide, but both must be taken seriously and watched carefully at least for three months. *Edwin S. Shneidman and Normal L. Farberow, Clues to Suicide. Pub. Health Rep. Feb.* 1956.

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## Nature of keloids

The familial and hereditary nature of keloids offers the opportunity for a useful approach to further investigation of the nature of keloids. In the study of familial and hereditary diseases one has at one's disposal, close together, a group of affected individuals which permits observation of the disease in its variations and association with other abnormalities. This type of study has proved its value in obscure hereditary diseases and it may help to throw some light on the pathogenesis of keloids. *David Bloom, M.D. Heredity of Keloids. New York J. Med. Feb.* 15, 1956.

# CORRESPONDENCE



## Rocky mountain cancer conference

The 10th Annual Rocky Mountain Cancer Conference will be held in Denver, July 11 and 12, 1956. This conference is sponsored by the Colorado State Medical Society and the Colorado Division of the American Cancer Society. Two full days of scientific talks are scheduled with a noon round table discussion of the subjects presented during the forenoon session.

Among the guest speakers, are: Lauren V. Ackerman, St. Louis; George V. Brindley, Temple, Texas; Charles L. Dunham, Washington, D.C.; Charles Huggins, Chicago; Dwight H. Murray, Napa, California, president elect of the A.M.A.; Eugene P. Pendergrass, Philadelphia; Grant H. Sanger, New York City; John R. Schenkin, Omaha, Nebraska.

For complete program and additional information, write to John S. Bouslog, M.D., Chairman, Cancer Conference Committee, 835 Republic, Denver 2, Colorado.

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## Ford foundation announces matching funds

On April 15, a $10,000,000 program of matching grants was announced by Mr. H. Rowan Gaither, President of the Ford Foundation.

These grants will be paid to the National Fund for Medical Education on a sliding scale in a program that could last up to ten years but might be accelerated to completion in five years, depending upon the rate at which additional contributions are developed.

In 1955 the National Fund received $2,147,000 in unearmarked funds for distribution to the nation's medical schools. Of this amount, $422,812 came from the medical profession through the American Medical Education Foundation in unearmarked monies. Under the Ford Foundation formula, if these receipts are of equal magnitude in 1956, there would be a Ford Grant totalling 70 percent of this amount, or $1,503,486; and all contributions in excess of the 1955 total would be matched dollar for dollar subject to the annual maximum of $2,000,000.

In succeeding years the preceding year's receipts would be matched on a diminishing scale, but all receipts over the preceding year's total would be matched dollar for dollar, up to the $2,000,000 annual ceiling.

This new appropriation is totally distinct from the $90,000,000 (endowment) appropriation announced by the Ford Foundation in December which will be paid directly to the schools after consultation with an advisory group still to be formed.

In announcing the grant to the National Fund for Medical Education, Mr. Gaither said, "The Ford Foundation is aware of the critical needs of the nation's medical schools and of the threat to the national welfare posed by their current plight.

"The Foundation hopes that grants under this appropriation will assist in efforts to stimulate the interest and response of the medical profession and of the general public, to the end that financial support for medical schools can be

maintained at a level consistent with sound medical education."

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The material above was taken directly from a news release issued by the Ford Foundation. It is wonderful news to hear that every dollar we receive in unearmarked funds and transmitted through the National Fund For Medical Education to the medical schools will be matched in part or in whole by these grants.

Throughout the country many physicians have asked why should they give through the A.M.E.F. to the schools? This is the answer. We now have a strong argument for our 1956 efforts. Every dollar we give above last year's gifts will mean two dollars for the medical schools.

Further clarification of this announcement will be forthcoming soon.

John W. Hedback,
Executive Secretary,
American Medical
Education Foundation

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## Clinics for crippled children listed for July

Twenty four clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing service. There will be 3 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The July Clinics are:

July 3 - Hinsdale, Hinsdale Sanitarium
July 10 - E. St. Louis, St. Mary's Hospital
July 10 - Peoria, Children's Hospital
July 11 - Carrollton, Carrollton Grade School
July 11 - Joliet, Will County T.B. Sanitarium
July 12 - Cairo, Public Health Building
July 12 - Elmhurst (Cardiac), Memorial Hospital of DuPage County
July 12 - Springfield, St. John's Hospital
July 12 - Sterling, Field House
July 13 - Chicago Heights (Cardiac), St. James Hospital
July 17 - Alton, Alton Memorial Hospital
July 17 - Danville, Lake View Hospital
July 17 - Quincy, St. Mary's Hospital
July 18 - Evergreen Park, Little Company of Mary Hospital
July 19 - Flora, Clay County Hospital
July 19 - Rockford, St. Anthony's Hospital
July 20 - Evanston, St. Francis Hospital
July 24 - Effingham (Rheumatic Fever), St. Anthony's Hospital
July 24 - Peoria, Children's Hospital
July 25 - Aurora, Copley Memorial Hospital
July 25 - Springfield (Cerebral Palsy), Memorial Hospital
July 26 - Bloomington, St. Joseph's Hospital
July 26 - Mt. Vernon, Masonic Temple
July 27 - Chicago Heights (Cardiac), St. James Hospital

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## Conference on aging

The Conference on Aging to be held in Ann Arbor, July 9-11, 1956, will deal with the topic "Health for the Aging," medical and social services. It is being planned by members of the Geriatrics Committee of the Michigan State Medical Society and the Departments of Post Graduate Medicine and Gerontology of the University of Michigan.

A large part of the meetings will be devoted to clinics for doctors of medicine dealing with specific diseases in elderly patients. There will also be groups dealing with the many other problems in the gerontologic field such as geriatrics education in medical schools and hospital training programs; the many social and psychologic aspects of the older person; rehabilitation of the physically and mentally handicapped as well as a consideration of the standards and activities in nursing homes and homes for the aged. In each group there will be persons of experience and ability so that a highly, successful and stimulating conference will be assured.

Research Seminars will also be held at which the biologic aspects of aging, medical research

problems, and the social psychologic viewpoints will be discussed by outstanding research scientists of national reputation.

Final program will be available in the June issue of the Journal Michigan State Medical Society.

For information contact A. Hazen Price, M.D., Chairman, Michigan State Medical Society, Geriatrics Committee, 62 W. Kirby Ave., Detroit 2, Michigan.

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## The American Institute of Dental Medicine

The Annual Meeting of the American Institute of Dental Medicine will take place at El Mirador, Palm Springs, California, November 4 to 8, 1956. The faculty will consist of:

Dr. Francis L. Chamberlain, Associate Clinical Professor of Medicine, the University of California, San Francisco, who will speak on cardiovascular disease, with all its implications for the personal health and welfare of the dentist and physician, as well as emergencies in professional practice. He also will discuss the problem of fat metabolism (closely related to that of cardiovascular disease) and problems of geriatrics.

Dr. Milton B. Engel, Associate Professor of Orthodontics, the University of Illinois, College of Dentistry, will consider the structure of connective tissue — morphological, chemical and physiochemical; the labile behavior of the connective tissue in health and disease; connective tissue and the milieu interieur; the formation and resorption of bone; and the implications of these general ideas in dentistry.

Dr. Donald A. Kerr, Professor of Oral Pathology and Periodontia at the University of Michigan, has suggested the following subjects: The pathology of traumatic temporomandibular arthritis produced by traumatic occlusion; gingivitis, its differential diagnosis and treatment; and keratotic lesions of the oral cavity.

Dr. Helmut A. Zander, Professor of Periodontology, the University of Minnesota, will discuss the rationale of the prevention and treatment of oral diseases which will include such subjects as: tissue reaction to dental calculus and reaction of periodontal tissues to filling materials; mechanism of healing of periodontal lesions; and effects of restorative dentistry on the pulp and management of pulp exposures.

Dr. S. I. Hayakawa, San Francisco State College, is well known throughout the country as the author of numerous books and publications in the field of general semantics. He will discuss: Why we don't behave like human beings; the self-concept: why we reject some ideas and welcome others; communication as a two-way process; success and failure in communication.

All seminar lecturers will participate in a round table forum discussing the application of their subject to the practice of dental medicine. Because of the mounting interest in this annual meeting of the Institute, early registration is indicated. Applications and full information may be secured from the Executive Secretary, Miss Marion G. Lewis, 2240 Channing Way, Berkeley 4, California.

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## Radioisotopes in medicine

The U. S. Atomic Energy Commission has issued an 817-page book, "Radioisotopes in Medicine," which is the complete proceedings of a special course on the subject, which was conducted by the Oak Ridge Institute of Nuclear Studies in September of 1953.

The book contains 48 chapters, divided into nine main sections, complete with bibliography, index, charts, and illustrations. Editors are Gould A. Andrews, Marshall Brucer, and Elizabeth B. Anderson of the ORINS Medical Division.

Lecturers in the course, whose discussions are presented in the book, included outstanding authorities in the fields of medicine and radioisotopes from throughout the United States. Contents of the book include papers concerning availability and uses of isotopes, problems in radiation, radiation measurement and dosimetry, tumor localization, diagnostic and therapeutic uses of radioiodine, metabolic and vascular studies, isotopes in the study and treatment of hematologic disorders, therapy with radioactive colloids, and therapy with external and implanted sources.

"Radioisotopes in Medicine" is on sale from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D. C. Cost is $5.50 with paper cover.

## Comprehensive course in occupational medicine

A full-time eight-week comprehensive course in occupational medicine for physicians will be given in the Post-Graduate Medical School of New York University-Bellevue Medical Center from September 10 through November 2, 1956, it was announced by Dr. Norton Nelson, Chairman of the Institute of Industrial Medicine.

Among the subjects being offered to physicians are: organization and administration of an industrial medical department; preventive and constructive medicine in industry; occupational diseases; toxicology and industrial hygiene for the physician; as well as biostatistics, communicable disease control and epidemiology. Opportunities will be provided for attendance at medical, surgical and clinico-pathological conferences during the course.

For further information and application address: Dean, N.Y.U. Post-Graduate Medical School, New York 16, N. Y.

Tuition. $350.

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## Ciba's "Medical Horizons" TV series to return on September 9

"Medical Horizons," Ciba's medical documentary television series, will return this fall for a minimum of 39 weeks on ABC-TV, it was announced by T. F. Davies Haines, president of Ciba Pharmaceutical Products Inc. The program will be seen each Sunday from 4:30 to 5:00 p.m., New York time, on an 85-station national network starting September 9.

The 1955-56 "Medical Horizons" series, presented in co-operation with the American Medical Association, ended on March 7 after 26 weeks on a network of 42 ABC-TV stations.

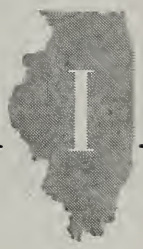
"We trust that the greatly expanded coverage and continuity of the 1956-57 series," states Mr. Haines, "will inspire increased confidence in the American medical profession. We plan to have programs on advances in common everyday problems in medicine as well as on major diseases which as yet have not been fully conquered," he adds. "The future of medicine looks bright," Mr. Haines concludes, "and we in the pharmaceutical industry are proud to have a part in the progress made toward better health."

Don Goddard, veteran newscaster, will return as narrator. The series will again be packaged by the J. Walter Thompson Agency of New York under producer-directors Bob Foster and Bill McCarthy and under the supervision of Dr. William T. Strauss of Ciba.

Programs were presented on the training of the medical student (University of Pennsylvania) and the doctor (Johns Hopkins), the work of the hospital nurse (Cornell Medical Center), the diagnosis and management of liver diseases (Jersey City Medical Center), the use of the heart-lung bypass (Mayo Clinic), the artificial kidney machine (Georgetown University), the causes of headache (Duke University), the effect of temperature and humidity on the human body (University of St. Louis), the human factors in motor vehicle accidents (University of Colorado), and many other interesting medical subjects.

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# AT THE EDITOR'S DESK



Every Illinois physician may have among his patients one or more members of TOPS (Take Off Pounds Sensibly). This national organization of stout women is not static. Members who are able to maintain a slim figure must get a doctor's certificate attesting to this fact. This allows them to graduate into KOPS (Keep Off Pounds Sensibly). It's all a physician can do nowadays to keep up with Medic, Reader's Digest, and organizations like TOPS.

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Toothprints offer the second best characteristics for use in identification. A thief was not thinking of this when he took three bites out of a piece of cheese while robbing a grocery store. The cheese was used as evidence in court and the prosecuting attorney clinched the case when he obtained expert testimony showing "that the chances of another person's leaving exactly the same dental markings in the cheese were sixty million to one."

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The Diuretic Review states that white wines produce greater diuresis than red wines because of the high concentration of potassium salts in sweet wines. This information will be picked up by La Presse Medicale but medical journals in the U. S. A. would be more interested in the effects along this line of martinis, old fashioneds, and bloody Marys.

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New drugs for old diseases and new uses for old drugs department.

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Searle recently introduced their new anabolic steroid, Nilevar.® It is 1/16th androgenic and has three major beneficial uses: It reverses negative nitrogen balances, improves appetite, and enhances the feeling of well being. It should be useful in hastening postoperative recovery and improving the nutritional status of patients with severe illnesses and chronic diseases.

News releases have appeared on the effective use of the vasoconstrictor, Levophed® (norepinephrine) in coronary shock. Relief was obtained in 50 per cent of the cases.

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Pediatric Piptal® is ballyhooed as a treatment of colic in infants.

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Storcavite was announced to the public as a nutritional supplement during pregnancy and lactation, It is rich in minerals and vitamins but differs from rival products in that its calcium is "prepared from purified, powdered oyster shell."

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News releases continue to pour out on Miltown®. The caption on one reads "Miltown relieves pain of cancer in 23, eliminating dependence on opiates." Another reads "Miltown aids four out of five patients in two year study at mental hospital."

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Laboratory technicians will be interested to know about a new plastic, transparent microscope slide that won't break or scratch. Robert Busse & Co. of New York offers these slides at 1½c each.

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Mice will be interested in the new drug, D.O.N., which is useful in the treatment of mouse tumors. The product inhibits the formation of nucleic acids from smaller chemical fragments.

# NEWS of the STATE

## ADAMS

**Society News.**—"Tuberculosis Problems of the Practicing Physician" was the subject of Dr. David D. Radner before the Adams County Medical Society at its meeting in Quincy, April 9. Dr. Radner is medical director of the Winfield Hospital, Winfield, and chest physician on the staff of Michael Reese Hospital, Chicago.

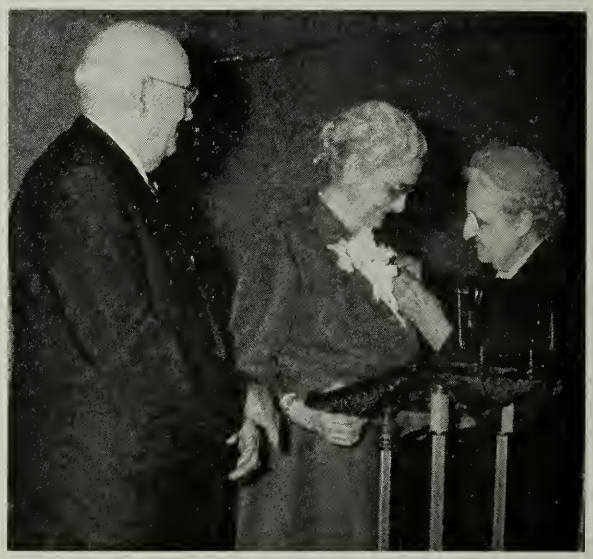
## BOND

**Tribute to Beloved Physician.**—Dr. Kate B. Luzader, Greenville, was honored at a dinner meeting, May 2, when more than 200 persons gathered to pay official tribute to her completion of fifty years in the practice of medicine. The affair was sponsored jointly by the Bond County Medical Society and such community organizations as the Kiwanis Club, Chamber of Commerce, Garden Club and the Ladies' Council of Bond County.

Dr. Luzader received the certificate and pin which are emblematic of membership in the Fifty Year Club of the Illinois State Medical Society. Presentation was made by Dr. Arthur Goodyear, Decatur, Councilor of the Seventh District. At his request, Dr. Clare A. Garber, Decatur, also a Fifty Year Club member and a life-long friend of Dr. Luzader, did the pinning. Ten physicians were on the rostrum during the ceremony. Dr. William L. Hall, Greenville, President of the Bond County Medical Society, "emceed" the program.

Among the speakers were Mayor of Greenville, Paul Zebb, and Dr. Arkell M. Vaughn, Chicago, Past President of the Illinois State Medical Society. A native of Greenville, Dr. Vaughn reviewed briefly the careers of the early physicians of Bond County.

The entire program was carried on in true "This Is Your Life" style. Bess Moss, reporter for the Greenville Advocate, was the narrator during the screen projection of slides and pictures of events in Dr. Luzader's career. At the request of Dr. Luzader, Miss Moss read a prepared statement acknowledging the town's tribute and in which she credited the community with ninety-five per cent of all she had accomplished. When the reading was concluded, Dr. Luzader spoke briefly. "Some of you may think that old age is what the trouble is with me," she said, but it isn't old age—it's the mileage."



**Dr. Kate B. Luzader receives her Fifty Year Club pin from Dr. Clare A. Garber as Dr. D. T. Brown smiles his approval.**

## CLINTON

**New Officers.**—Dr. M. A. Bateman was recently elected president of the Clinton County Medical Society. Other officers are Dr. W. L. DuComb, vice-president and Dr. J. Q. Roane, secretary-treasurer. Dr. Bateman is delegate to the Illinois State Medical Society and Drs. DuComb and Roane, the alternates. Members of the Board of Censors are Drs. Roane, three years; E. C. Asbury, two years and Fred Pulgram, one year.

## COLES-CUMBERLAND

**Postgraduate Conference.**—On April 26, the Postgraduate Education Committee of the Illinois State Medical Society in cooperation with members of the faculty of Cook County Graduate School of Cook County Hospital held a postgraduate conference at the Villa Nova in Mattoon, with the Coles-Cumberland County Medical Society acting as host. The program included a panel discussion on Medical Emergencies with the following speakers: Drs. Arthur Bernstein, medicine; William J. Pickett, surgery, and Frank J. Fara, obstetrics and gynecology. Other speakers were Drs. Aaron Grossman on Newborn and Pediatric Age; Edwin C. Graf, Urology, and Dr. Pickett, What We Should Know About Peripheral Vascular Diseases. Dr. Harlan English, Danville, presided. At the evening dinner meeting, Dr. Arkell M. Vaughn, Chicago, Past President of the Illinois State Medical Society, spoke on "The Responsibility of Citizenship for the Physician and His Wife."

Twenty leading pharmaceutical firms had exhibits at the conference and acted as hosts at a Fellowship Hour in the evening.

## COOK

**Dr. Plotke Named to Stritch Faculty.**—Dr. Frederick Plotke, chief of the public health service of the Illinois Department of Public Welfare, has been appointed assistant professor of preventive medicine and public health at Stritch School of Medicine of Loyola University.

**Ricketts Medal Goes to John Bugher.**—Dr. John C. Bugher, director of medical education and public health, Rockefeller Foundation and former deputy director of the Atomic Energy Commission, received the Howard Taylor Ricketts Medal of the University of Chicago May 9. Dr. George V. LeRoy, associate dean of the Division of Biological Sciences of the university, made the presentation, after which Dr. Bugher spoke on "Changing Patterns in Public Health."

The Ricketts Prize was established in 1910 by Mrs. Howard Taylor Ricketts in honor of Dr. Howard Ricketts who died of typhus. While a member of the staff of the University of Chicago, Dr. Ricketts proved the spotted fever is transmitted by a tick. The causative organism now bears his name.

The Medal, given annually by the University of Chicago in recognition of outstanding work in medical research, went to Dr. Bugher for his research on the public health aspects of virus diseases and the biological and medical effects of atomic energy.

**Personal.**—Dr. Walter L. Palmer was installed as president of the American College of Physicians at a recent meeting in Los Angeles.—Dr. John P. Waitkus was recently named a life fellow of the International Academy of Proctology.

**Program to Link Hospital Patient's Spiritual and Physical Care.**—Effective June 1, the Rev. Granger Westberg will assume a joint professorship of religion and health at the University of Chicago. The appointment is a part of the University's School of Medicine's plan to link hospital patients' spiritual and physical care, the Chicago Daily News reported April 4. The newly created joint professorship is under the joint auspices of the school of medicine and the Federated Theological Faculty. The Rev. Westberg has served as chaplain of University Clinics and associate professor of pastoral care since 1952.

**D. J. Davis Memorial Lecture.**—Carlos I. Reed, Ph.D., professor of physiology, University of Illinois College of Medicine, delivered the Annual D. J. Davis Memorial Lecture on Medical History, May 9. His subject was "John Morgan, Father of the First American Medical School."

**Channing Barrett Now Living in Missouri.**—Friends and former students of Dr. Channing W. Barrett, formerly of Chicago, will be happy to know that he is living with his daughter, Mrs. Howard Bush, in Neosho, Mo. Dr. Barrett was for many years professor and head of the department of obstetrics and gynecology, University of Illinois College of Medicine.

**Faculty Appointment.**—Dr. Robert C. King, an authority on the genetic effects of atomic radiation, has been appointed assistant professor of biological sciences at Northwestern University. Dr. King, who holds a doctorate in genetics from Yale University, will teach elementary and advance courses in genetics including study and experiments in plants and animal mutations and radiation genetics.

**Psychiatric Problems in Medical Practice.**—Dr. Marc H. Hollender, associate professor of psychiatry, University of Illinois College of Medicine, gave the ninth and last lecture in the Sixth Annual North Shore Health Resort Lecture Series on Psychiatric Problems in Medical Practice, June 6, His subject was "Utilization of Community Resources in Medical Practice." The Commission on Education of the American Academy of General Practice has approved these lectures for informal credit. The J. B. Lippincott Company of Philadelphia will publish the entire series as a book. All royalties that will accrue have been assigned to the American Psychiatric Association. Dr. Walter C. Alvarez, consultant in medical emeritus, Chicago Mayo Clinic, gave the previous lecture, May 9, on "Prevention of Iatrogenic Disorders."

**Introduction to the Behavioral Sciences.**—Dr. James L. Cate, professor of medieval history, University of Chicago, on April 10 opened a series of lectures at the Chicago Medical Society on the behavioral sciences. Professor Cate gave an introduction to history. Others in the series were William R. Bascon, professor of anthropology, Northwestern University, April 17, on Anthropology; David Riesman, professor of social sciences, University of Chicago, May 8, Sociology; Roulf A. Weil, professor of economics, Roosevelt University, on May 15, Economics, and Howard P. Hunt, professor and

chairman of the department of Psychology, University of Chicago, on May 22, Psychology.

**Tempory City Epidemiologist Named.**—Dr. O. C. Wenger, formerly medical director of the U.S. Public Health Service, and now retired, has been named epidemiologist for the Chicago board of health. Dr. Wenger, who succeeds Dr. William Fishbein, will serve until a civil service appointment is made, newspapers report.

**Cardinal Stritch Honored.**—Cardinal Stritch was guest of honor, April 28, at a dinner given by 200 psychiatrists, members of the Guild of Catholic Psychiatrists. Auxiliary Bishop Joseph M. Marling, Kansas City, was the principal speaker; his subject was "Opportunity Beckons the Catholic Psychiatrist."

**Industrial Meeting.**—The Chicago Society of Industrial Medicine and Surgery was addressed, May 9, by Dr. C. H. Hatcher, professor of orthopedic surgery, University of Chicago, on "Fracture Through Pathologic Bone", and B. S. Quigley, regional attorney, Liberty Mutual Insurance Company, "Medico-Legal Aspects of These Unusual Fractures."

**English Neurologist Gives Kaplan Lecture.**—The Chicago Neurological Society was addressed, May 1, by Sir Charles Symonds, consultant neurologist, Guy's Hospital and National Hospital for Nervous Diseases, Queen Square, London, on "Hughlings Jackson's Fifth Factor in the Insanities: Local Disolution." The lecture was presented under the auspices of the Leo A. Kaplan, Memorial Lectureship affiliated with the Phi Delta Epsilon Foundation of Chicago and the Chicago Neurological Society.

**Lewis Hospital Observes Silver Jubilee.**—A solemn pontifical mass in St. James Church, April 21, commemorated the silver jubilee of Lewis Memmorial Maternity Hospital. The mass was celebrated by Cardinal Stritch, Roman Catholic archbishop of Chicago. At a luncheon the same day, Mrs. Georginanna Vadder, Bensonville, the first person born at the hospital, was honored as a feature of the anniversary celebration. Others who attended this luncheon were department heads at the hospital, physicians associated with it both presently and in the past, and Knights of St. Gregory. A second luncheon was held in the hospital for members of the Mothers club and hospital employes. Mr. Frank J. Lewis, 89 year old philanthropist, who financed construction of the hospital and who also donated a million dollars to renovate it, served as honor guard to Cardinal Stritch at the church ceremony. Mr. Lewis is the only papal count in the Americas, newspapers reported. He was named to this position by Pope Pius in 1954.

**Special Society Election.**—At the annual business meeting of the Chicago Opthalmological Society Dr. Frank W. Newell, was named president-elect to assume duties in 1957. Dr. Kenneth L. Roper, succeeds Dr. Daniel Snydacker, as president for the current year. Other newly elected officers include Dr. Orville Gordon, vice-president, succeeding Dr. Edward Albers, Champaign, Illinois; Dr. Joseph S. Haas, secretary-treasurer, succeeding Doctor Newell; and Dr. John B. Hitz of Milwaukee, Wisconsin, councilor, succeeding Dr. Edward Leiss, of Appleton, Wisconsin. Dr. David Shoch, was re-named corresponding secretary.

**New Hospital Planned for Skokie Valley Area.**—Plans to construct a hospital serving the Skokie Valley area were announced, April 19, according to the Chicago Tribune. The new hospital would be on the northeast corner of the intersection of Waukegan and Golf roads and would serve Northfield, Northbrook, Glenview, Golf, Morton Grove, Skokie and Lincolnwood. Tentatively the name selected is Old Orchard Community Hospital. According to the newspaper report, construction would be in three stages, the first providing 105 beds with all necessary medical and surgical facilities and the second and third about 100 beds each.

**Staff Election.**—Dr. Herbert T. Nash was recently chosen president of the Mercy Hospital medical staff for a two year term. Other officers are: Drs. Peter A. Nelson, vice-president; Robert L. Schmidt, secretary-treasurer; Arkell M. Vaughn, William J. Pickett, John F. Sheehan, Harry A. Oberhelman and George F. O'Brien, executive committee.

**Carroll L. Birch Honored.**—Dr. Carroll L. Birch, professor of medicine at the University of Illinois College of Medicine, recently received the Elizabeth Blackwell medical citation at the New York Infirmary in "recognition of her distinguished achievement in the study and teaching of tropical medicine." Dr. Birch was cited for her studies and investigations on tropical medicine in many parts of the world, including equatorial Africa. Just a few months ago Dr. Birch returned from India where she spent three years as head of the Lady Hardinge Medical College and Hospital. A feature of the presentation was the address by Dr. Birch on "Elizabeth Blackwell, First Women Physician."

**Presbyterian and St. Luke's Hospital Merge.**—A proposed merger of St. Luke's and Presbyterian Hospitals was approved, April 12, by the boards of both institutions. The consolidated board will have 48 members, 24 from each institution. Ralph A. Bard Sr., president of Presbyterian's board of managers, will be chairman of the merged board. John P. Bent, president of the St. Luke's board, was elected president. The two institutions will occupy enlarged facilities on the present Presbyterian site at 1753 Congress Street. Newspapers reported that the merger will involve a three building program to cost approximately 11 million dollars. The hospitals now have a combined capacity of 969 beds. Of these Presbyterian has 416 and St. Luke's, 553. Dr. Karl S. Klick, director of Presbyterian Hospital, has been named director of the new Presbyterian-St. Luke's Hospital. Joseph P. Greer was named assistant director. He is now director of St. Luke's Hospital and will continue in that capacity until

the physical merger of the two hospitals is accomplished, the Chicago Tribune reported, May 7.

**Leslie Arey Honored.**—A portrait of Dr. Leslie B. Arey featured the annual faculty-alumni reunion dinner of Northwestern University, May 12. The portrait, painted by Chiago artist Edmund Geisberg, was presented by Dr. Richard H. Young, dean of the medical school. More than 600 colleagues and former students were at the reunion to honor Dr. Arey for his forty-one years' service on the Northwestern faculty and for his contributions to the field of anatomy.

Dr. Arey retired as chairman of the department of anatomy and Robert Laughlin Rea professor of anatomy at the close of the school year in June. He will continue to teach and carry on research at Northwestern. Best known as an authority on embryology, Dr. Arey wrote the classic "Developmental Anatomy," a standard textbook used by nearly every premedical and medical student.

Another part of reunion's program was the presentation of golden year certificates to members of the fifty-year class who graduated at Northwestern in 1906. The class was honored at a special luncheon. A contribution to the alumni fund was presented at the reunion by members of the graduating senior medical class. They were welcomed into the alumni Association by Dr. Leonard F. Jourdonais, president of the medical division.

## LAKE

**Society News.**—The Lake County Medical Society was addressed at St. Therese's Hospital in Waukegan, April 10, by Dr. F. Lee Stone, President-Elect of the Illinois State Medical Society, on "Social Economics of the Medical Profession" and by Mr. R. G. Van Burskirk, executive secretary of the Committee of Legislation, American Medical Association on "Congress, Doctors, and Politics."

## MACON

**Society News.**—Dr. Herbert P. Friedman, pathologist, Carle Hospital Clinic, Urbana, spoke on "Hemolytic Anemias" before the Macon County Medical Society in Decatur recently.

## MADISON

**Society News.**—"The Foreign Trained Physician in America" was the subject of Dr. Duff S. Allen, St. Louis, member of the Missouri State Board of Medical Examiners, before the Madison County Medical Society in Edwardsville, April 5.

## PEORIA

**Society News.**—At a meeting of the Peoria Medical Society, April 17, the speakers were Drs. Henry Wilson on "Infectious Hepatitis"; Charles Branch, "Indications for Exploration of the Common Duct"; and Paul R. Dirkse, "Intravenous Cholangiography."

## ST. CLAIR

**Society News.**—A symposium on radiology was presented before the St. Clair Medical Society at the Pleasant View Sanatorium, Belleville, May 3. Participants were Drs. F. E. Bihss, N. R. Shippey, J. A. Crilly and W. S. Broker.

**Postgraduate Conference.**—The Postgraduate Education Committee of the Illinois State Medical Society in cooperation with the staff of St. Luke's Hospital, Chicago, presented a postgraduate conference in Belleville, April 5, with the Belleville Branch of the St. Clair County Medical Society acting as host. The speakers were Drs. Foster McMillan on "Newer Concepts in the Management of Intestinal Obstruction"; George K. Fennin, "New Concepts of Digitalis Therapy"; Arthur L. Ratko, "Re-evaluation of the Diagnosis and Treatment of Chronic Ear Disease", and Robert A. Beebe, "New Concepts in the Diagnosis and Treatment of Lesions of the Cervix". Dinner speakers were Dr. Willard W. Fullerton, Sparta, Councilor of the Tenth District, and Mr. Edward E. Lindsay, Decatur, Editor of the Lindsay Schaub Newspapers, who spoke on "Medical Economics" and "Medical Writing and Reporting", respectively.

## VERMILION

**Society News.**—Dr. J. Edwards Tether, assistant professor of neurology, Indiana University Medical School, Bloomington-Indianapolis, discussed "Fatigue" before the Vermilion County Medical Society at the Hotel Wolford in Danville, May 1. The society was addressed at the Veterans' Facility, Danville, April 3, by Dr. Fred Reynolds professor of orthopedics, Washington University School of Medicine, St. Louis, on "Problems of the Herniated Nucleus Pulposus."

**Personal.**—Dr. Alfonso Baquero, Rankin, has been elected into membership of the Vermilion County Medical Society for the probationary period of one year.

## WARREN

**Rotary Club Told About Nurse Shortage.**—Dr. John O. Firth, member of the Committee on Nursing of the Illinois State Medical Society, addressed the Monmouth Rotary Club, April 30, on the acute shortage of nurses in Illinois and the nation. Dr. Firth, who is chairman of the American Legion 40 & 8 committee for nurse recruitment in Illinois and a director of the national committee for nurse procurement, estimated that the United States will be 55,000 nurses short this year. The 40 & 8 gives financial assistance to girls wanting to go into nurses training in the way of tuition and uniforms. Warren-Henderson County voiture has sponsored three girls so far in the program and next year will sponsor three more.

According to the Monmouth Review Atlas, Dr. Firth said that the 40 & 8 discovered that they had more difficulty finding schools to send the girls to than finding girls interested or funds to send them.

Eighteen nurses' training schools have closed in the state in the last four years. There are only seventy operating currently.

## GENERAL

**Nutrition Meeting.**—The Chicago Nutrition Association, in cooperation with the Committee on Nutrition of the Illinois State Medical Society, sponsored a program on the theme that every child has a good nutritional start in life, April 26. Speakers included: Paul A. Dailey, M.D., chairman, Committee on Nutrition, Illinois State Medical Society; Father Joseph Mangan, S.J., Moral Theologian, St. Mary's of the Lake Seminary, Mundelein, Illinois; Thelma Porter, Ph.D., professor of nutrition and chairman of the Committee on Home Economics, University of Chicago; Grant Laing, M.D., assistant professor of medicine, Northwestern School of Medicine; H. Close Hesseltine, M.D., professor and secretary of the department of obstetrics, University of Chicago; and James R. Wilson, M.D., president of the Chicago Nutrition Association.

**Teachers Receive Chest X-rays.**—During January 11,619 teachers and other school employees in Illinois received chest X-rays through the services of the mobile units of the Illinois State Department of Public Health. The Illinois Health Messenger reported that among this group, 12 active cases of tuberculosis were discovered. Eight of these are in the beginning or minimal stage of the disease; one case is moderately advanced; and three cases are in the far advanced stage. Fifty-nine of the X-rays showed evidence of tuberculosis that has already healed.

The X-raying of teachers and other school personnel is a new phase of the tuberculosis control program of the State Department of Public Health. It is a result of recently enacted legislation prohibiting the employment in schools of persons suffering from tuberculosis in a communicable form.

The intimate association of teachers and other school personnel with children makes the X-raying of this group of our population of particular importance. By assuring that such employees are free from tuberculosis, the risk of exposure of children to this disease is being greatly reduced.

**New Contacts by Public Health Service Continue Cancer Research.**—The U. S. Public Health Service has placed contracts with five laboratories for large-scale screening of chemical compounds in the search for drugs useful in treating cancer, it was announced March 29. The laboratories, which will begin the work at once, are: Microbiological Associates, Bethesda, Maryland; Wisconsin Alumni Research Foundation, Madison Wisconsin; Southern Research Institute, Birmingham, Alabama; Hazelton Laboratories, Falls Church, Virgina; and Stanford Research Institute, Menlo Park, California. Responsibility for supervising the contracts rests with the Cancer Chemotherapy National Service Center of the Public Health Service National Cancer Institute in Bethesda, Maryland. It is expected that the laboratories will test approximately 2,000 compounds by July 1. Each compound will be tested against three different kinds of cancer implanted into various strains of mice bred for cancer susceptibility, under procedures for animal screening established by a panel of the Cancer Chemotherapy National Committee. This committee, representing the leading organizations and goverment agencies in the field of cancer research, was established last may to sponsor a national voluntary program of cooperative research and development in cancer chemotherapy. At present the only cancer cures are achieved by surgery or radiation, but some forms of cancer, such as acute leukemia, are not amenable to these treatments. Other forms may be diagnosed only after they have spread throughout the body, too late to be benefited by either surgery or radiation. In such cases, chemical treatment appears to offer the greatest hope. Compounds now in use have been successful in prolonging the useful life of patients suffering from cancers of the breast and prostate, and cancers of the bloodforming tissues, such as leukemia and lymphoma. They are not curative.

**"Your Doctor Speaks" on FM Station WFJL.**—The following physicians have recently appeared in transcribed broadcasts of FM Station WFJL, Thursday evenings at 7:45 p.m. The series, entitled "Your Doctor Speaks" is presented by the **Educational Committee** of the **Illinois State Medical Society:**

**Ralph T. Lidge,** instructor in orthopeic surgery, University of Illinois College of Medicine, April 12, Broken Bones in Old People.

**Rudolf Dreikurs,** professor of psychiatry, The Chicago Medical School, April 26, Knowing Ourselves.

**Alfred E. Falk,** head of the department of dermatology, Children's Memorial Hospital, May 3, Skin Diseases in Childhood.

**Harry H. Garner,** professor of neuropsychiatry, The Chicago Medical School, The Chicago Medical School, May 10, Treatment Possibilities for the Patient with Emotional Problems.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Harry W. Southwick,** clinical assistant professor of surgery, University of Illinois College of Medicine, Licensed Practical Nurse Association of Illinois in Chicago, April 25, on Cancer.

**Howard S. Traisman,** assistant attending pediatrician, Children's Memorial Hospital, Daniel Boone Parent-Teacher Association, May 2, on Social Development in Relation to Physical Health.

**Paul K. Anthony,** clinical instructor in pediatrics, Stritch School of Medicine of Loyola University, Eberhart Elementary School Parent-Teacher Association, May 8, Health Problems Facing the School Age Child.

**Jack Fischer,** professor of medicine, University of Illinois College of Medicine, B'nai Zion Golden Age Club, May 23, on Facts and Fancies About Heart Disease.

**"Youth Week" Lectures Arranged by the Educational Committeee for the Chicago Medical Society and the Chicago Board of Education:**

**Frederick L. Phillips**, attending pediatrician at St. Luke's Hospital, Yale Elementary School, May 3, Hints to Healthy Living.

**Lawrence Breslow,** clinical assistant professor of pediatrics, University of Illinois College of Medicine, Jones Commercial High School, May 9, Teen Age Tips on Health.

**Robert K. Hagan,** member of the pediatric staff, Little Company of Mary Hospital, Raster Elementary School, May 10, Hints on Healthy Living.

**Robert E. Lee,** associate clinical professor of medicine, Stritch School of Medicine of Loyola University, Whitney Elementary School, May 11, on Health and Happiness.

**Lectures Arranged Through the Scientific Service of the Illinois State Medical Society:**

**James E. Segraves,** clinical assistant in bone and joint surgery, Stritch School of Medicine of Loyola University, Lee-Whiteside County Medical Societies in Dixon, May 10, on Treatment of Fractures of the Tibia with Special Reference to Intermedullary Rod Fixation.

**Clinton L. Compere,** assistant professor of orthopedic surgery, Northwestern University Medical School, Champaign County Medical Society, May 10, on Bone Tumors.

**James A. Schoenberger,** assistant professor of medicine, University of Illinois College of Medicine, Stock Yards Branch, Chicago Medical Society, May 11, on What, When and Why in Albuminuria.

**Frederick L. Phillips**, attending pediatrician at St. Luke's Hospital, Iroquois County Medical Society in Watseka, May 15, on Management of Vomiting and Diarrhea in Children.

**Morris T. Friedell,** associate professor of surgery, Stritch School of Medicine of Loyola University, June 19, 1956, on Radioistopes Application to Medicine and Medical Research.

**Tilden Everson,** clinical assistant professor of surgery, University of Illinois College of Medicine, Whiteside-Lee County Medical Societies in Rock Falls, June 21, on Surgical Aspects of Gastrointestinal Diseases.

**Harry F. Dowling,** professor and head of the department of medicine, University of Illinois College of Medicine, DeKalb County Medical Society, in Sycamore June 26, on Use and Abuse of Antibiotics.

## DEATHS

**Edward Aron,** Chicago, who graduated at the University of Illinois College of Medicine in 1933, died April 30, aged 51. He was a member of the staff of Mt. Sinai Hospital.

**Frederick R. Bennett***, Chicago, who graduated at Rush Medical College in 1929, died April 12, aged 53. He was formerly head of the staff of Little Company of Mary Hospital and a past president of the Calumet Branch of the Chicago Medical Society.

**Louis S. Cholden***, formerly of Chicago and recently of Los Angeles, who graduated at Chicago Medical School in 1947, April 26, aged 37; he was injured fatally in a traffic accident while enroute to the Los Angeles airport to board a plane to Chicago to attend the annual meeting of the American Psychiatric Association.

**Ruth Darrow***, Chicago, who graduated at Rush Medical College in 1930, died April 23, age 60. She had been a member of the staff of the Women's and Children's Hospital for 20 years.

**Nathan Smith Davis, III***, Winnetka, who graduated at Rush Medical College in 1913, died April 20, aged 66. He was professor emeritus of medicine of Northwestern University Medical School and a member of the staff of the Chicago Wesley Memorial Hospital, a fellow of the Academy-International of Medicine, of which he had been president and secretary, and of the American College of Physicians.

**Daniel R. Dwyer***, Ottawa, who graduated at Loyola University School of Medicine in 1927, died April 4, Aged 60. He was a member of the American Trudeau Society.

**James J. Ellis***, West Frankfort, who graduated at St. Louis College of Physicians and Surgeons in 1909, died January 24, aged 73, of pneumonia, following an operation.

**Bruno Eric Epstein,** Chicago, who graduated at Northwestern University Medical School in 1955, died February 22, aged 25.

**Joseph W. Friedlander***, Chicago, who graduated at Ohio State University College of Medicine, Columbus, in 1943, died May 5 in his office, aged 41.

**Walter B. Gerhard***, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1907, died April 23, aged 72. He was president of the staff of Northwest Hospital.

**Jacques Grandoit,** Chicago, who graduated at Ecole Nationale de Médecine et de Pharmacie, Port-au-Prince, Haiti, in 1947, died January 21, aged 33.

**Millard Holloway Irwin,** Nokomis, who graduated at the University of Louisville Medical Department in 1910, died in St. Francis Hospital, Litchfield, January 28, aged 68, of cancer of the prostate.

**George H. Jackson, Jr.,***, Evanston, who graduated at Harvard Medical School in 1918, died April 11, aged 66.

**Harry L. Kampen***, Monmouth, who graduated at Eclectic Medical College, Cincinnati, in 1892, died April 16, aged 90. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

**Albert Lessing***, Quincy, who graduated at the Harvey Medical College in 1903 and the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died January 19, aged 79, on coronary occlusion.

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*Member of Illinois State Medical Society

**Emanuel Levy,** Oak Park, who graduated at Jenner Medicine College in 1914, died in the Oak Park Hospital on March 3, aged 69, of arteriosclerotic heart disease.

**George M. Landau*,** Chicago, who graduated at the University of Illinois College of Medicine in 1915, died April 10, aged 65. He was assistant professor of radiology at Northwestern University Medical School, formerly president of the Chicago Roentgen Society, and Director of the X-ray and Therapy Department at Cook County Hospital since 1942.

**Charles L. Leppert*,** Rockford, who graduated at Rush Medical College in 1930, died March 25, aged 54. He was former president of the staff of St. Anthony's Hospital.

**Myron E. Lollar*,** Tuscola, who graduated at the University of Illinois College of Medicine in 1913, died April 4, aged 79.

**Paul G. Matthis,** Chicago, who graduated at Northwestern University Medical School in 1926, died May 5, aged 60. He was a member of the staff of Provident Hospital.

**Gordon Charles McNeil*,** River Forest, who graduated at Northwestern University Medical School in 1943, died February 3, aged 38. He was a member of the staff of the Walther Memorial Hospital.

**Clarence O. Norris*,** Arthur, who graduated at Bennett Medical College, Chicago, in 1915, died March 12, aged 74.

**Joseph P. Reich*,** Chicago, who graduated at the University of Heidelberg, Germany, in 1911, died April 23, aged 68. He was a member of the staff of the Michael Reese and West Side Veterans Hospitals.

**Ethyl Harriet Richardson,** retired, Quincy, who graduated at the American Medical College, St. Louis, in 1899, died January 21, aged 76, of arterial embolism.

**David L. Schramm*,** Chicago, who graduated at Northwestern University Medical School in 1900, died April 29, aged 79. He was senior attending physician, department of internal medicine, at Michael Reese Hospital.

**Paul Jeffrey Schutz*,** Chicago, who graduated at the University of Illinois College of Medicine in 1944, died March 2, aged 34, of a brain tumor. He was captain in the Medical Corps, Army of the United States Air Force, from 1945 to 1947.

**John T. Sullivan, Sr.*,** retired, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1914, died April 15, aged 77.

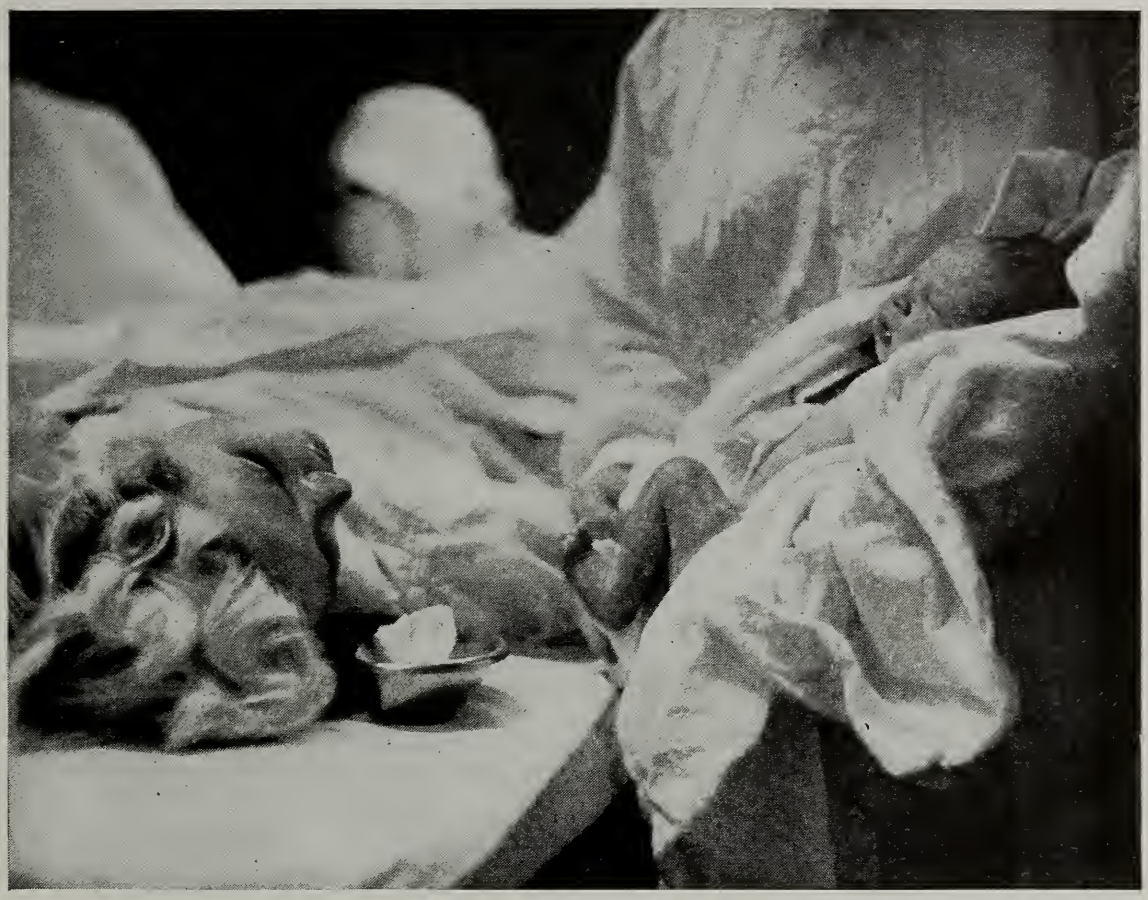
**Charles Crain Winning*,** East St. Louis, who graduated at the American Medical College, St. Louis, in 1911, died January 26, aged 69. He was associated with St. Mary's and the Christian Welfare Hospitals, and for many years was local physician and surgeon for the Illinois Central Railroad.

*Member Illinois State Medical Society

## Peripheral neuritis in diabetics

This disease occasionally produces a peripheral type of neuritis which may closely simulate sciatica. The neuritis may appear when the diabetes itself is under satisfactory control, with the patient's urine sugar free and blood sugars normal or near normal. Whether, in such cases, the peripheral neuritis is related to prolonged use of insulin is problematic, but the fact remains that diabetic patients with sugar metabolism in good control may have in their later years a disabling peripheral neuritis characterized by muscle pains, areflexia, and hyperesthesia of the skin. *John M. Meredith, M.D. Differential Diagnosis of Low Back, Hip, and Leg Pain in Elderly Patients. Geriatrics, March* 1956.

Today it is generally accepted that an educated and enlightened group of citizens can and do best solve their own health problems, those of their families and their communities. Moreover, the nature of today's health problems—chronic disease, mental health, and accident prevention—demands that in addition to technical skills all health workers must be capable of utilizing educational and community organization procedures. We must not be guilty of telling people what to do, but we must help them become the kind of people who will know what to do. L. E. Burney, M.D., Cal. Med., Jan. 1956.



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Lessens anxiety, tension and fear; reduces
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# BOOK REVIEWS

THE NEUROSES IN CLINICAL PRACTICE. Henry P. Laughlin, M.D., Assistant Clinical Professor of Psychiatry, George Washington University School of Medicine; Head, Psychiatry and Neurology Division, Suburban Hospital, Bethesda, Maryland; Consultant in Psychiatry, Walter Reed Army Medical Center. W. B. Saunders Company Philadelphia, Pp. 802. 1956. $12.50.

Although the title suggests that this is yet another book in the currently popular field of psychiatry in general medicine, this is actually a scholarly and thorough textbook of psychopathology. The author has been an active campaigner for more precise psychiatric terminology. This is evident in the book in which clear, concise definitions are interspersed with case reports and discussion. The major neuroses are discussed as entities and important concepts are summarized in tabular form. Case reports are well-chosen and are clearly and briefly presented, something which is lacking in many psychiatric books.

Little space is devoted to therapy. The author appears to believe that formal insight psychotherapy is the only satisfactory treatment for the neuroses. He offers little in the way of substitute for the majority of cases in which intensive psychotherapy is not available, acceptable, or practical.

An interesting feature of the book is a section on so-called "brain washing", apparently the first discussion of this subject in a psychiatric textbook. The author emphasizes that in the subtle techniques of the Soviet regime "modern psychological knowledge has been traumatically applied in an endeavor that is antitherapeutic."

This book is recommended to physicians who are already in possession of psychiatric knowledge and experience and who wish an up-to-date review of psychopathology. The book is of less value to physicians practicing general medicine.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

BASIC OTOLARYNGOLOGY. By Francis L. Lederer, B. Sc., M.D., F. A. C. S., F. I. C. S. (Hon.) Professor and Head of Department of Otolaryngology, University of Illinois College of Medicine, Chicago, and Abraham R. Hollender, M. Sc., M.D., F. A. C. S., Professor of Otolaryngology, Emeritus, University of Illinois College of Medicine, Chicago. Illustrations, 11 in color. Fourth edition. F. A. Davis Company, Philadelphia, $6.75.

ESSENTIALS OF DERMATOLOGY. Fifth Edition. By Norman Tobias, M.D., Formerly Associate Professor of Dermatology, St. Louis University. J. B. Lippincott Company, Philadelphia 5, Pennsylvania. $8.00.

CANCER CYTOLOGY AND CYTOCHEMISTRY. Annals of the New York Academy of Sciences. Volume 63, Art. 6, pages 1033-1462. Editor, Roy Waldo Miner. By M. J. Kopac and 51 other specialists. $4.50.

ASCITES TUMORS AS TOOLS IN QUANTITATIVE ONCOLOGY. Annals, Vol. 63, Art. 5. By T. S. Hauschka and 40 other investigators. 393 pages, illustrated. $4.50.

IN THE DOCTOR'S OFFICE — The Art of the Medical Assistant. By Esther Jane Parons. Second edition. J. B. Lippincott Company, $3.95.

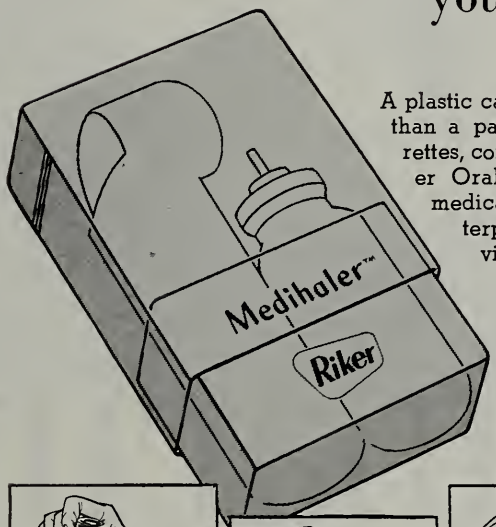
(*Continued on page* 54)

# New... *and a Major Advance in Treatment of*

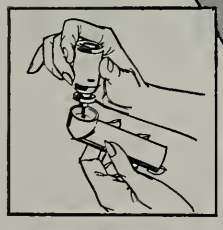
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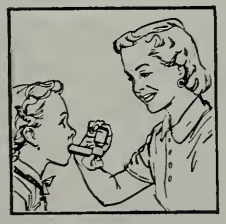
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## BOOKS RECEIVED (Continued)

THE ROCHESTER REGIONAL HOSPITAL COUNCIL. By Leonard S. Rosenfeld, M.D., M. P. H., and Henry B. Makover, M.D. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts. $3.50.

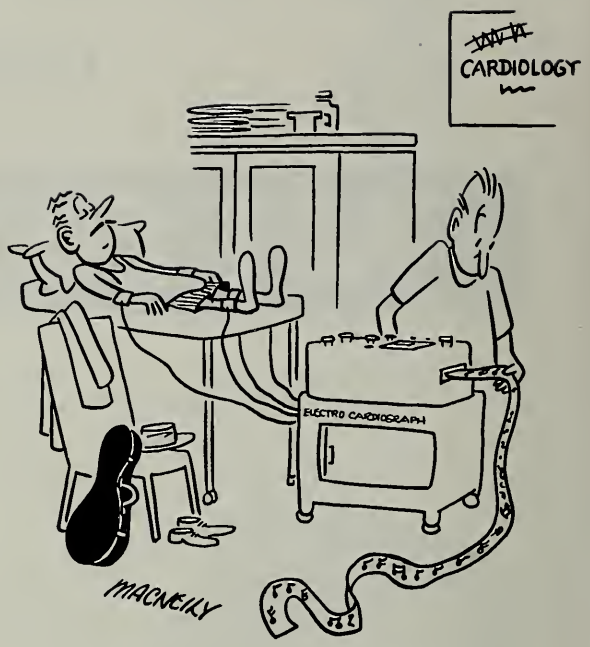
MODERN TREATMENT YEARBOOK, 1956. A Yearbook of Diagnosis and Treatment for the General Practitioner. Edited by Sir Cecil Wakeley, Fellow of King's College, London; Senior Surgeon, King's College Hospital. $6.00.

BELLEVUE IS MY HOME. By Salvatore R. Cutolo, M.D., Deputy Medical Superintendent of Bellevue Hospital, with Arthur & Barbara Gelb. Doubleday & Company, Inc. $4.00.

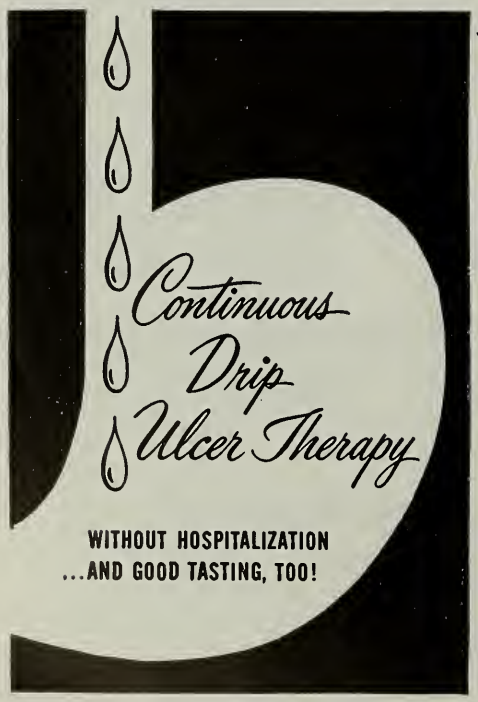
PULMONARY CARCINOMA — pathogenesis, diagnosis and treatment. Edited by Edgar Mayer, M.D. and Herbert C. Maier, M.D. New York University Press, New York. Distributed by J. B. Lippincott Company, Philadelphia and New York. $15.00.

TEXTBOOK OF MEDICAL PHYSIOLOGY. By Arthur C. Guyton, M.D., Professor and Chairman of the Department of Physiology and Biophysics, University of Mississippi School of Medicine. Illustrated. W. B. Saunders Company, Philadelphia and London. $13.50.

YOUR BLOOD PRESSURE AND HOW TO LIVE WITH IT. By William A. Brams, M.D. Illustrations by Hertha Furth. J. B. Lippincott Company, Philadelphia and New York. $2.95.








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*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

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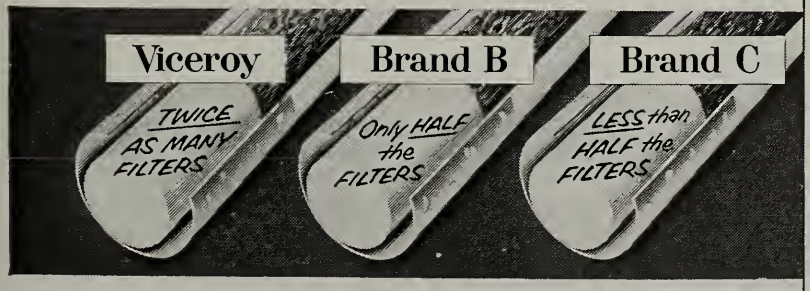



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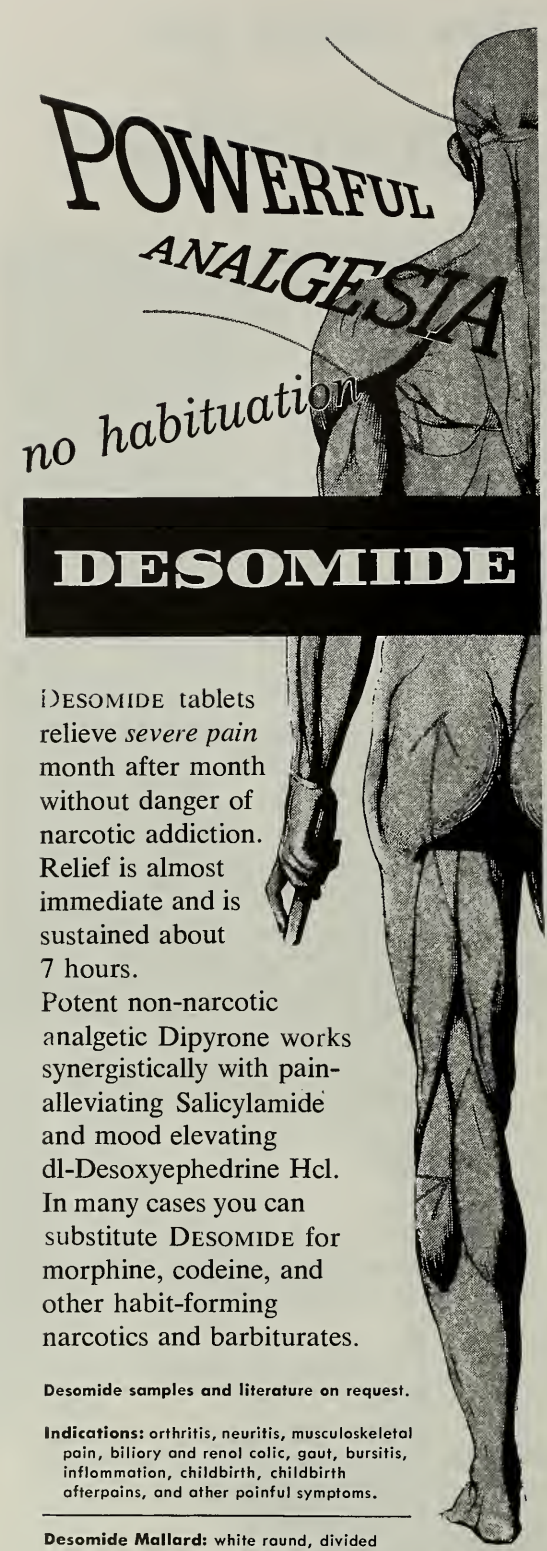
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**Desomide Mallard:** white round, divided tablet contoining Dipyrone 100 mgs., Salicylomide 100 mgs., dl Desoxyephedrine Hcl 1.5 mgs.
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## A look at home care

The recent increase in home treatment of tuberculosis patients has been much discussed. Some patients have always been treated outside hospitals, either from preference or because of a shortage of beds. Now with more effective treatment methods it is reasonable to broaden home treatment criteria if quality of medical care can be maintained.

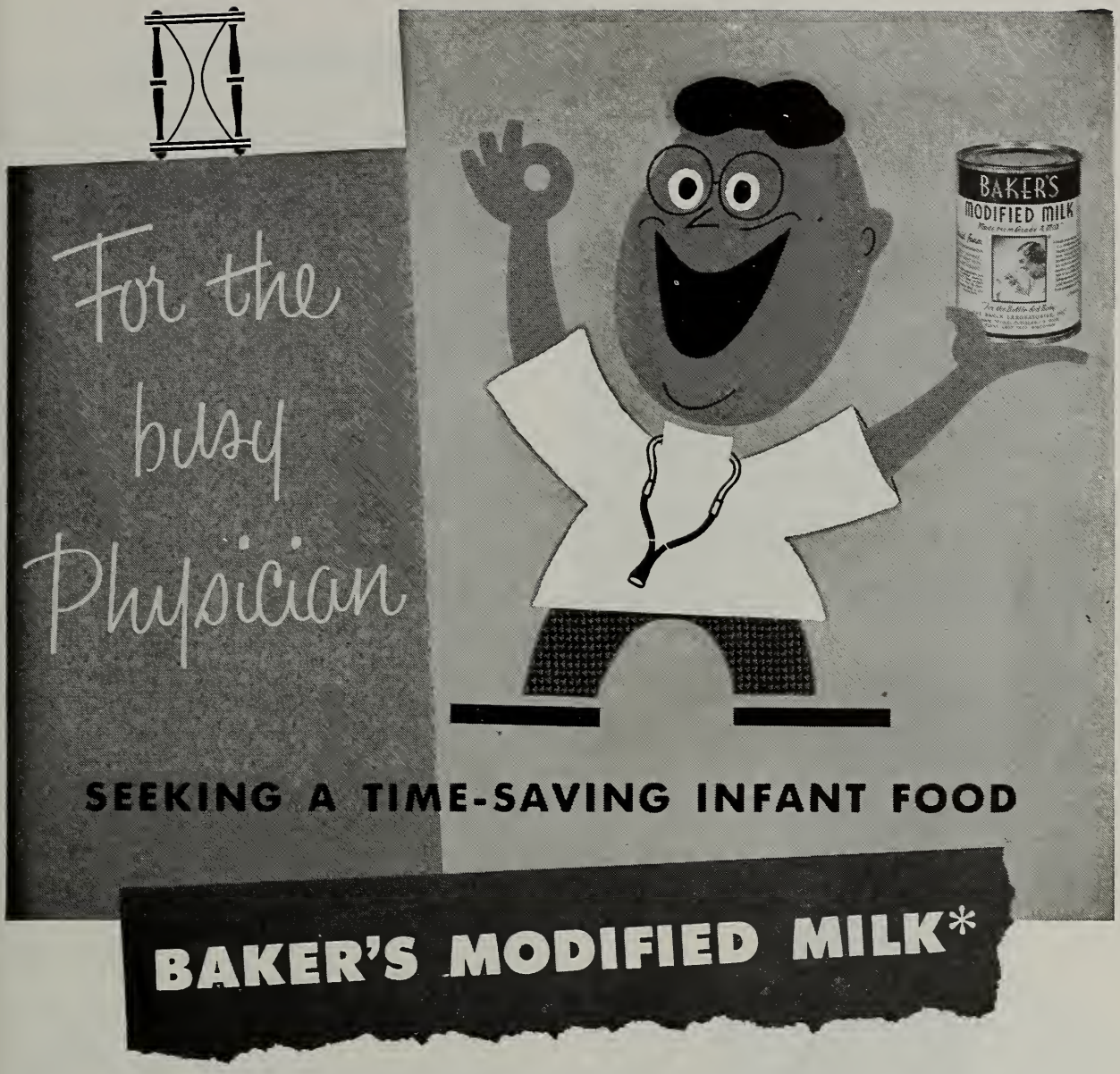
Whether or not the idea is good, home care is already widely practiced. What is needed now is a critical evaluation of unhospitalized patients and criteria for the selection of patients and for providing suitable medical care. Experience with chemotherapy is still of short duration and there are many unanswered questions regarding its efficacy. In adapting chemotherapy to home treatment the limitations should be considered.

Streptomycin and isoniazid are highly effective when properly administered. Isoniazid can be given by mouth and parenteral injections of streptomycin can be made by visiting nurses or in clinics. Symptomatic response is prompt, and the volume and infectivity of pulmonary secretions are usually reduced. Present knowledge indicates that, to be effective, treatment must be prolonged for a year or more and must be continuous, that streptomycin and isoniazid are best given in combination or with para-aminosalicylic acid, and that surgical treatment is often necessary.

These drugs are usually not dangerous, but rarely toxic manifestation may require a change in drug regimen. Toxicity usually develops early and complications can be avoided if new cases are hospitalized during the preliminary period. Drug therapy is more often limited by the onset of bacterial resistance to the drugs, which is encouraged when therapy is interrupted or drugs are not given in proper combination. Extra efforts must be made to insure continuance of therapy when patients are treated outside the hospital.

Adequate observation of patients receiving drug therapy requires frequent clinical and roentgenologic observation and detailed laboratory studies. Since drug therapy is usually dramatically effective in relieving symptoms and is apt to encourage false optimism, thorough education of the patient is important at the onset and

(*Continued on page* 60)




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## HOME CARE (Continued)

throughout treatment. It is difficult to achieve the same degree of understanding during brief office and clinic visits that is possible in the hospital.

It must be recognized that there are advanced cases of tuberculosis which cannot be cured and the patient remains a respiratory cripple. Although hospitalization provides only custodial care for these patients, outside the hospital they are potentially dangerous to the community. The patient at home is not necessarily ambulatory, and if needed rest at home is impossible, the patient should remain in the hospital. Additional benefits of rest should not be compromised in order to treat the patient at home.

As treatment methods become simpler and more easily administered, it may be anticipated that the specialist will deal only with the more complicated clinical situations. Unfortunately, the past isolation of tuberculosis patients has also isolated clinical experience and knowledge. Medical students, residents and practicing physicians need more experience and instruction regarding tuberculosis.

In the past hospitalization has been urged not only for the patient's benefit but also to isolate him during the infectious period. Does drug therapy reduce the danger of contagion sufficiently to ignore this safeguard? Factual data are needed before this question can be answered. It seems wise, however, to combine drug therapy with precautionary measures. The patient at home and his familial contacts should be carefully instructed as to hygienic precautions and kept under close observation.

Some enthusiasm for home care is based on the assumption that it is less expensive. For the self-supporting patient, home care may be less costly than prolonged hospitalization, but when treatment is at community expense this saving is less certain. The patient still requires medical and nursing care, must be housed and fed, and his family must be assisted. This cannot be assumed to be inexpensive until overall costs have been studied.

In the hospital the patient can be provided with medical and other necessary services. When patients are geographically dispersed, services become difficult to provide and the treatment team, including doctors, nurses, social workers,

(*Continued on page* 62)

# BETTER

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# BREATHING

capacity is greatly enhanced. "Relief of symptoms is more complete and maintained for longer periods with relatively small doses."[2]

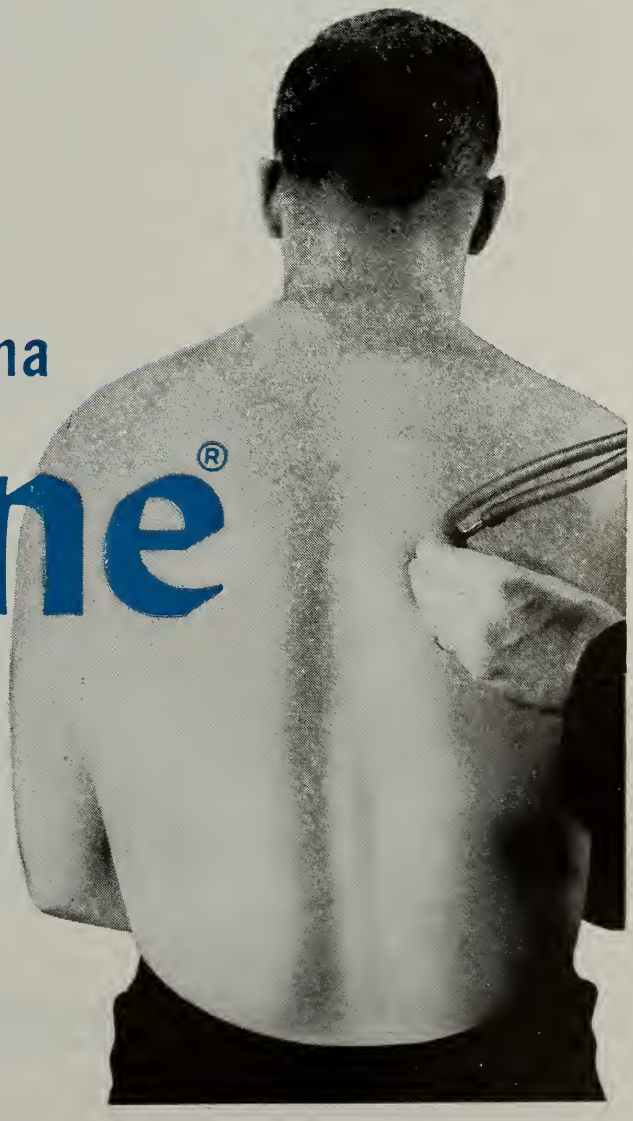
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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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**HOME CARE (Continued)**

vocational counselors, public health nurses and recreation workers may be too dispersed to be efficient. Provision of such services for unhospitalized patients is a challenging problem. Relapse is now less frequent following effective treatment, but relapse potentialities still exist and may be decreased by careful rehabilitation.

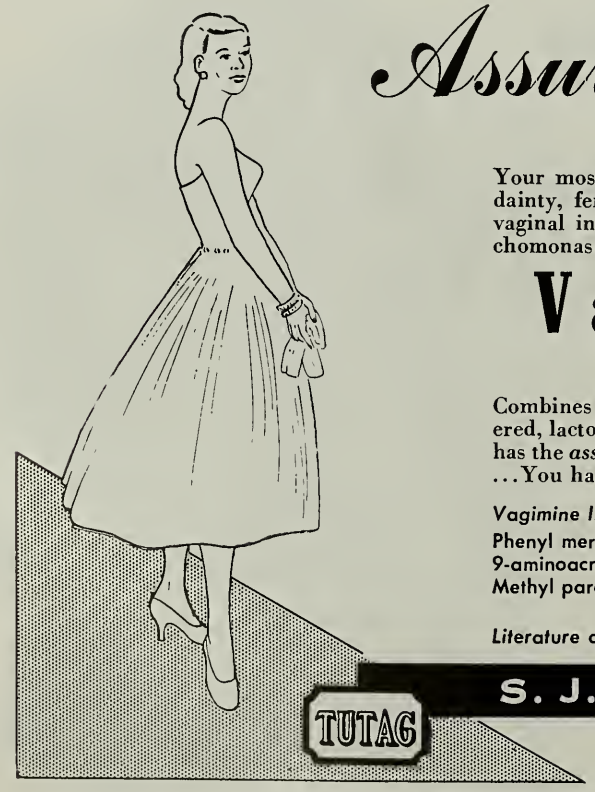
Home treatment offers advantages for selected patients if all clinical and personal needs can be met. Family integrity can be maintained with the patient as a participating member. The successful "home treatment" patient must assume greater responsibility for his conduct and treatment, thus avoiding attitudes of dependency. The home should be physically adequate and family relationships must be sound.

Application of home treatment is limited for the numerous detached, homeless men who attend clinics from unsheltered living situations. Many of these patients adapt poorly to institutional life. In general the poorly adjusted individual is a poor patient inside or outside a hospital.

During the period of preliminary hospitalization for new tuberculosis cases long-range plans can be formulated after doctors, social workers, and vocational advisors have evaluated individual needs. When suitable clinical response has been made, the patient can return to a well-planned home situation. Ideally he will then continue under supervision of the same staff. Later surgical therapy may be necessary and this can be performed as part of a well integrated, continuous program of treatment. If home treatment cannot be combined under the auspices of the hospital in which treatment began, detailed information and plans should be transferred to the patient's private or clinic physicians and social workers.

Hospital services are needed for new cases, for the clinically ill, and for specialized services such as thoracic surgery. The asymptomatic patient on prolonged drug therapy and the convalescent patient under continuing clinic supervision can be treated at home if suitable arrangements can be made.

(*Continued on page* 64)

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1. Blank, P., and Boas, H.: Ann. West. Med. & Surg. 6:376, 1952.
2. Piper, C. E., and Nicklas, F. W.: Indust. Med. 23:510, 1954.

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**HOME CARE (Continued)**

Much is to be gained from sharing experience in a period of change. A pooling of information from various parts of the country where home treatment programs are in progress should contribute to our understanding of the questions which have been posed regarding home treatment of tuberculosis.

*Julia M. Jones, M.D.*, Bulletin, National Tuberculosis Association, *September, 1955.*

» «

With the advent of the newer drugs, and the great advance in surgery of the lungs, medical progress has slowly converted tuberculosis from a killing to a chronic disease. This is a great achievement. But, in changing the course from a killing to a chronic state, tuberculosis handicaps its victims, thereby creating a huge financial and emotional problem, which eventually threatens, with its ever increasing size, to stifle the medical economy of our communities. I. Phillips Frohman, M.D., Ohio State M.J., August, 1955.

## Restricted diet in liver damage

Much of our information concerning the prevention of liver injury may not be directly applicable to the cure of established disease. A stage may be reached where irreversible changes occur in liver tissue. It is probable, for example, that deficiency of lipotropic factors, such as choline, is a major factor in causing cirrhosis of the liver in the chronic alcoholic but the administration of choline itself has been disappointing as a specific therapeutic measure. On the other hand, general diet therapy may be very rewarding in these cases. Paradoxically, the same high-or moderate-protein diet which protects the liver from injury due to specific amino acid deficiencies may, in certain circumstances, prove deleterious once such injury has occurred. In acute necrosis and some cases of advanced cirrhosis, breakdown products of protein, thought to include ammonia, may lead to progressive coma and death. In these cases, diets restricted in protein have been beneficial. *Jeffrey H. Fryer, M.B., B.S. Some Recent Advances in Clinical Nutrition. J. Am. Dietet. A. Feb.* 1956.

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## Cardiac fluoroscopy

Cardiac fluoroscopy is an important part of the workup of patients with heart disease. It is not a substitute for clinical appraisal or other methods of investigation but is used to complement these, chiefly by supplying information regarding size, configuration, and dynamics of the heart chambers and large blood vessels. Occasionally an important finding in the differential diagnosis may be picked up only by this method. For example, the finding of calcium in a valve leaflet or in the pericardium may resolve an otherwise knotty diagnostic problem. Calcium in the aortic valve in patients with aortic murmurs immediately rules out a functional origin of the murmur and usually denotes aortic stenosis. Rarely, after extensive investigation, short of cardiac catherization or angiocardiography, is one unable to differentiate between mitral stenosis and interatrial septal defect. The finding of calcium in the mitral valve solves the problem. A point that is not commonly emphasized is the great importance of the accommodation of the eyes prior to fluoroscopy. As a rule, unless the fluoroscopist utilizes the red goggles or a darkened room for at least a full half hour, small areas of calcification will not be seen, and valuable diagnostic information will be overlooked. It might be added that calcification of the valves has an important bearing on the selection of patients for valvular surgery. In general, the presence of calcium in a stenotic valve makes surgery more difficult. *Franklin Berman, M.D. and W. Proctor Harvey, M.D. Curable or Reversible Forms of Heart Disease. GP, March* 1956.

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Little consideration has been given, until very recently, to even the *possibility* that different forms of tuberculosis, or different types of pulmonary tuberculosis, might be more satisfactorily treated by different drug regimens. On present evidence, it seems highly probable that the best management of tuberculosis will prove to be, not a single drug regimen which is optimal for all cases (as seems to have been the goal and the orientation of most investigations up to the present time), but that *different* regimens will be found to best suit different forms and types of the disease. Carl Muschenheim, M.D., Am. Rev. Tuberc., July, 1955.



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Each 2 cc. dose contains:

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## Mental adjustments in breast cancer

The impact of radical mastectomy and its natural inference of breast cancer stirs up, quite naturally, an intense emotional reaction within the patient. Cancer carries with it the constant threat of death associated with a lingering and painful illness. This can have a violently disruptive effect upon a patient's personality. In health we are characteristically oriented toward the future and our behavior is governed by a predictable sequence of events. These predictions rest upon the expectancy of a long life, and to most of us the concept of death is more or less remote. However, the abrupt awareness of breast cancer causes a drastic change in all of these personal probabilities. In order to deal realistically with this new and serious complication of life, a patient must make a number of mental adjustments. For some patients this is impossible and they resort to a variety of compensatory mechanisms as noted by Shands. These consist of suppression—keeping the status quo by noting but ignoring the unpleasant unreality; denial—disregarding obvious or suspicions signs of significance; disassociation—the imaginary splitting of one's personality into observer and patient; identification—charting the course of the present illness in terms of a similar operation having occurred to a friend or near relative, and several other psychologic defense mechanisms. It would be surprising indeed if the recognition of breast cancer did not result in reorientation and occasional flight from the disease. The risk of suicide is an ever present possibility and it is the physician's duty to guard against this hazard. *Edward F. Lewison, M.D. The Psychologic Aspects of Breast Cancer. GP, March* 1956.

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Tuberculosis case finding and reporting now are definitely superior to that of previous decades. For example, almost one-third of reported cases are found by X-ray survey. Fewer cases are first reported by death certificate. Even now, however, more than one-fourth of tuberculosis deaths were never reported as living cases. Large numbers of cases are not reported until the report of the sanatorium admission is received by the health department. Robert J. Anderson, M.D., Pub. Health Rep., Feb., 1956.




*the soothing, protective, healing*[1-4] *influence of*

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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

## Exchange of medical knowledge

Not many years ago doctors seldom got together. Since then there has been a much better and a more friendly feeling between the medical men. They seemed to fear one another. Consultations were few and far between. Today we see them mingle in medical societies, in hospitals, even with their families in social functions. I believe the average intelligence of our members is equal to the average intelligence of members of other societies. In the forward march of better living, I believe that the doctors have held up their end by their contributions and advancement of medical knowledge for the prevention and cure of physical ailments. We no longer see those pathetic pictures of suffering and death as we did in the past. With better living conditions and advanced medical knowledge, with the aid of the X-ray and laboratory facilities, doctors are better equipped to do better work; this has made life longer, safer, and more beautiful for all of us. *E. W. Marquardt, M.D. Recollections from 50 Years of Medical Practice. Read before the DuPage County Medical Society, Elmhurst, Ill.*

## Sedatives vs. poisons

A startling number of deaths occur from overdoses of so-called sleeping pills. The insurance contract may, and frequently does, exempt the company from liability from death resulting from poisoning as well as from suicide. When do such pills cease to be medicine or, if you please, sedatives, and become poison, if ever? In a number of adjudicated cases, the insurance companies paid because they were unable to prove that the insured took the overdose with the intent of self-destruction or was conscious of the fact that he or she was taking a lethal dose, although the autopsy and laboratory report may show the amount taken sufficient to kill several people. As a result of this situation, it has become necessary to add another exclusion in such contracts so as to exempt the companies from liability where death is caused directly or indirectly from poisons or barbiturates, whether taken intentionally or otherwise. *Joseph D. Frank. Certain Interrelationships of Medicine, Insurance, and the Law. J. Louisiana Med. A. Nov.* 1955.





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*integrated relief . . .*
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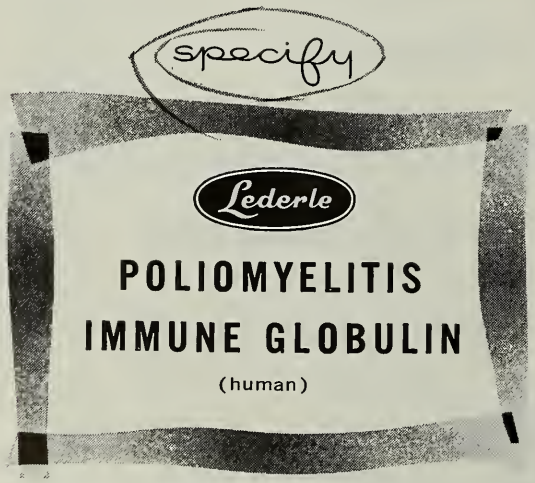
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## Hormones in allergy

Hormone therapy is not a substitute for the usual therapeutic measures used in the management of the allergic patient. In order to obtain complete and lasting benefit, specific treatment such as avoidance of the offending allergenic agents, and specific hyposensitization, are the best forms of therapy. However, the results obtained in symptomatic relief of allergic diseases with the corticosteroids far surpass those previously obtained with any other agent or procedure. The early use of corticosteroids in conjunction with the antibiotics for a period of two to seven days for asthmatic attacks ushered in by acute upper respiratory infection may not only decrease the duration and severity of the attacks but may also prevent the development of status asthmaticus. It should be understood that once hormone therapy is established, the usual therapeutic measures such as the use of epinephrine, iodides, intravenous glucose, antibiotics, and barbiturates should not be discontinued immediately. With the onset of relief, the usual therapeutic measures can be discontinued gradually. After relief has been established for a time, it may be possible to eliminate hormone therapy gradually. Relief may then be maintained by the usual therapeutic measures. Knowledge of the correct use of the hormones in allergic diseases is essential. Corticotropin, cortisone, hydrocortisone, prednisone, and prednisolone dramatically suppress many of the clinical manifestations of allergic diseases and are the most effective agents available at present for symptomatic relief in carefully selected cases after the usual therapeutic measures used in the management of the allergic patient have failed. *Emanuel Schwartz, M.D. Use of Hormones in the Treatment of Allergic Diseases. New York J. Med. Feb.* 15, 1956.

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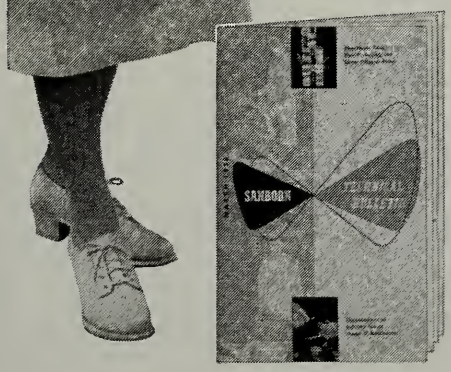
## Stays medicine

Advertising manager and vice president of the Maiden Form Brassiere Company ("...I dreamed I went. . . .in my Maidenform Bra. .") is Dr. Joseph A. Coleman. After two years of practice and five in the army, E. N. T. man Coleman went into the lingerie business. Dr. Coleman also holds a half dozen patents in brassiere design. *William B. McCunniff, M.D. Curiosa et Trivia. Missouri Med. Feb.* 1956.



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## What about the heart?

John Bunyan once referred to consumption as "Captain of the Men of Death" and, indeed, for many years in many parts of the world, tuberculosis led all other infectious diseases as a cause of death. During the first quarter of this century, however, according to Osler, pneumonia took over this title, having become the most widespread and fatal of all acute conditions. At present, tuberculosis is being reasonably well controlled by specific chemotherapy and other supportive measures. Pneumonia, or at least pneumococcal pneumonia, the most common form that was responsible for the high mortality in the past, also is no longer a cause for concern, since that disease responds promptly and decisively to any of a number of available antimicrobal agents. Evidence is now accumulating that, at least so far as hospitalized patients are concerned, top place as a cause of death has passed to the staphylococcal infections. *Editorial, "Captain Staphylococcus." New England J. Med. Feb.* 16, 1956.

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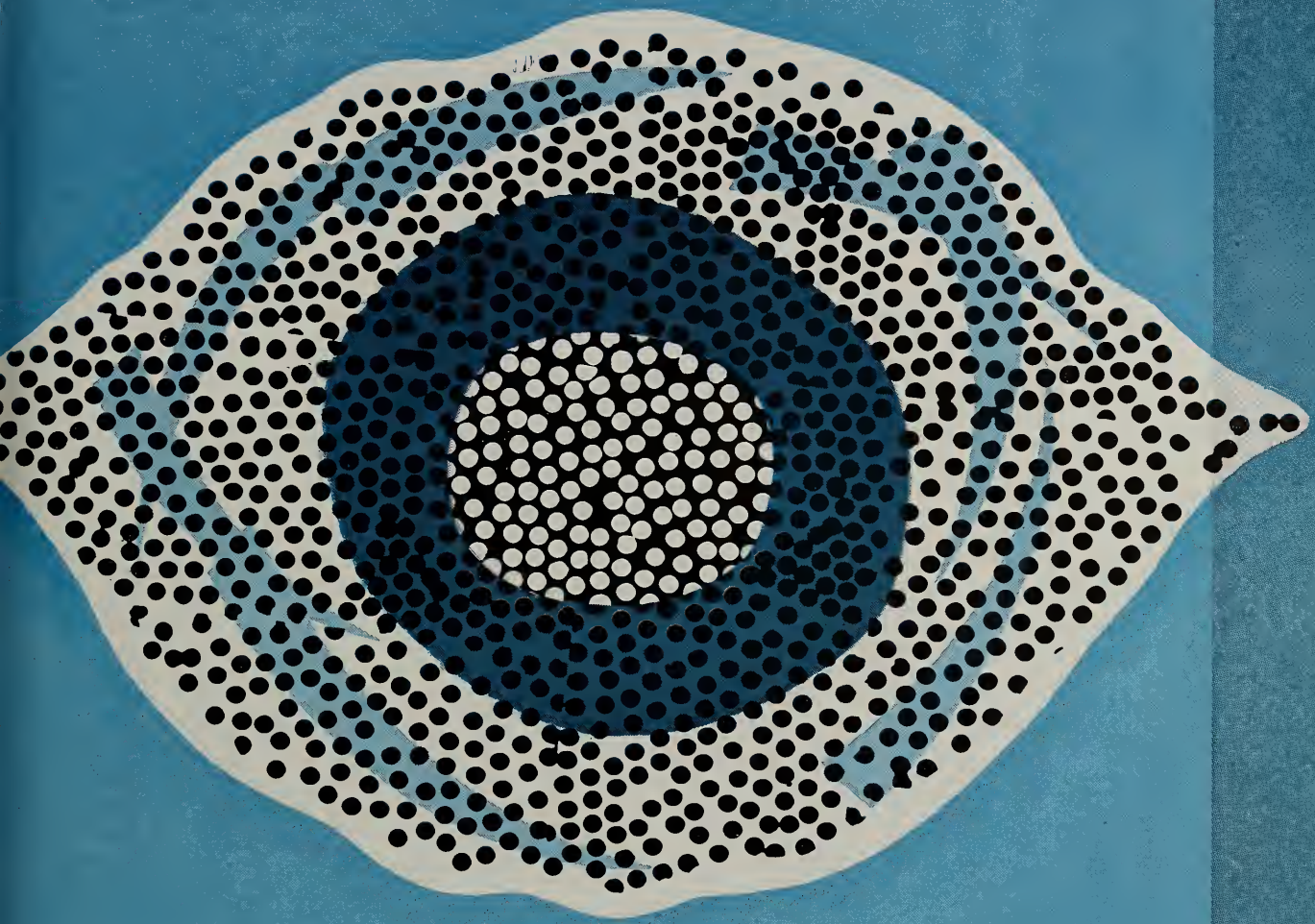
## Error in RBC

There is an inherent error of approximately 200,000 cell/mm 3 in the technique of the red blood count. A report of 3.9 million rbc/mm 3 occurring three days after a report of 4.2 million rbc/mm 3 does not necessarily represent blood loss or laboratory error. The technique of the red blood count is not that reliable. It is for this reason that many clinicians prefer the use of the hematocrit level in cases where significant blood loss is occurring. The hematocrit level, although more accurate than the red blood count, is not infallible; for in cases where there is fluid loss with blood loss, both tests may be misleadingly normal or high. *J. M. Jackler, M.D. Interpretations of Discrepancies in Laboratory Reports. J. Maine M.A. Feb.* 1956.

‹ ›

Practicing physicians can make valuable contributions to the health of the community, as well as to the health of children under their private care, by taking an active part in the health program of the schools. David Van der Slice, M.D., J. of School Health, May, 1954.

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## Dual code of ethics

We have a code of ethics, which apparently each of us is able to interpret individually. If medical schools, groups, clinics, and so on wish to inspire news stories through a third party, usually a public relations man, this seems to be acceptable. If, on the other hand, I — as an individual physician — choose to advertise diagnostic studies available in my office or if I choose to inspire a story in the public press concerning some research in which I may have been involved, I would not fare so well. Yet our ethical code states that both are governed by these same rules. Therefore, if we ourselves cannot interpret our own regulations on public stories, how can we be so hard on these gentlemen of the press? I stand only for a uniform policy on the part of both the profession and the press, a feeling that the public should be benefited by any stories, and an avoidance of sensationalism and fear psychology in newspaper and magazine stories. *William B. Walsh, M.D. What is Legitimate Medical News? Med. Ann. District of Columbia, Aug.* 1955.

## Back on the job

There are those who feel strongly that rehabilitation of injured workers is best conducted in centers serving the industrially injured alone; others favor a community center with a wing set aside for injured workers; many see no reason to separate the industrially handicapped from other disabled persons. The responsibility for the operation of a rehabilitation center can be the Commission's, the carrier's, or the community's. Centers now operating in California and the one contemplated in connection with the medical school at the University of California, Los Angeles, are examples of community centers. Specialized rehabilitation centers are sponsored by the workmen's compensation administrations or labor departments in Washington, Oregon, and Rhode Island. Insurance companies have established centers for the industrially injured in Massachusetts, Illinois, and Wisconsin. *Lisbeth Bamberger. Rehabilitation under Workmen's Compensation in California. Indust. Med. Feb.* 1956.


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## Variations in blood pressure recording

Discussion by some patients regarding the phenomena of different blood pressure readings by different individuals has yielded some interesting explanations. "I believe the younger and more intense or more interested doctors get higher readings. The older doctors don't seem to care so much what it is and get lower readings." Another patient says, "When I see the doctor and begin to talk over my problem, then I believe my pressure goes up. Just thinking about it gets me upset and when I see the doctor I must think and talk about this problem." Fear that the doctor, with his knowledge of disease, may make a dire prognostic interpretation of a reading he takes may elevate the blood pressure. One patient who was rejected for life insurance because of elevated blood pressure had normal readings when checked by the nurse, but much higher when checked by the doctor. He said, "I wasn't paying much attention when the nurse took my blood pressure but when the doctor did, I figured—this is what counts." *John R. Caldwell, M.D. and F. Wayne Hollinger, M.D. The Importance of Basal Blood Pressure. Henry Ford Hosp. Med. Bull. Dec.* 1955.

‹ ›

## A leader a-la-chinese

Twenty-five centuries ago, Laotzu, a Chinese philosopher and contemporary of Confucius, had this to say about leadership:

A leader is best
When people barely know that he exists,
Not so good when people obey and acclaim him,
Worst when they despise him.
"Fail to honor people,
They fail to honor you."
But of a good leader who talks little,
When his work is done, his aim fulfilled,
They will all say, "We did this ourselves."
*Ray H. Coffman. Management Development—Fad or Fundamental. J. Am. Dietet. A. Feb.* 1956.

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## Thoracic pain erroneously diagnosed

Various local conditions of the thoracic wall, such as myositis and arthritis of the spinal column, are only too frequently labeled coronary disease. Skeletal and muscular pain may be brought on or aggravated by effort but they are not so closely related to exertion as anginal pain is. Skeletal and muscular pain caused by effort tends to last much longer than angina from effort usually lasts. Use of the upper extremities, furthermore, is more likely to cause skeletal and muscular pain than is walking. Finally, when a patient complains of rheumatic types of pain, evidence of a similar disturbance elsewhere frequently is found. The muscles about the shoulder girdle and the tissues overlying the sacroiliac joints should be palpated carefully to detect the presence of tender fibrositic nodules. Musculoskeletal pains about the thorax frequently extend into either or both arms, a fact that is frightening because most laymen believe that pain which extends in this fashion is always caused by coronary disease. *Thomas J. Dry, M.B. Thoracic Pain in Cardiovascular Disease. Proc. Staff. Meet. Mayo Clin. Jan.* 11, 1956.

‹ ›

## A new test for measles

Another test that has been developed in our department is the nasal smear for measles. Most of us are able to be only suspicious of measles in those children with prolonged fever and bronchitis and must await the unreliable observation of Koplik's spots. If the glairy mucus around the turbinates of the nose is aspirated, using the curved glass tubing as is used in vaginal aspirations, then dropped on a glass slide, allowed to dry, and then stained with ordinary Wright's stain, one can diagnose prodomal measles days before the rash begins. This is accomplished by observing multinucleated giant cells which so far have been found only in measles. *Paul R. Patterson, M.D. Laboratory Aids in the Diagnosis of Pediatric Problems. New York J. Med. Feb.* 15, 1956.

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Health education has as many facets as there are health problems and each community must define the scope for itself. European Conf. on Health Ed. of the Public, London, England, April 10-18, 1953.



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References: 1. Hollander, J. L., *Ann. New York Acad. Sc.* **61**:511, May 27, 1955.
2. Hollander, J. L., *et al. J.A.M.A.* **158**:476, June 11, 1955.

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## Caviar lesions under the tongue

The caviar lesion is a small, roughly spherical, or dome-shaped varicose enlargement of the poorly supported veins in the collecting system under the tongue. The small ones develop as an outpouching of a branch of a communicating vein near the ranine veins. Pressure with a glass slide causes them to empty. Knots and clusters of such vessels with a dark blue or black color resemble caviar or buckshot. Anatomically, the caviar lesion is a dilated vein with hypoplastic endothelium but a fairly thick wall. There are no inflammatory changes. Age brings a sharp and fairly steady increase in incidence, as well as larger and more numerous lesions. *William B. Bean, M.D. The Changing Incidence of Certain Vascular Lesions of the Skin with Aging. Geriatrics, March* 1956.

‹ ›

While definite malnutrition plays a significant role in susceptibility to tuberculosis in man, nutrition is only one of the factors contributing to normal resistance. Alton S. Pope, M.D., and John E. Gordon, M.D., Am. J. Med. Sciences, Sept., 1955.

## Information from skin lesions

Lesions of the skin occasionally supply valuable information. In terms of curable heart disease, the outstanding examples are those found in bacterial endocarditis. The Osler node—a reddish, tender, pea-sized nodule often seen on the palmar surface of the finger or hand and lasting only a few days—is pathognomonic of subacute bacterial endocarditis. The Janeway lesion—a small, reddish, nontender, flat lesion on the palm—and the "splinter hemorrhage" beneath the nails, are very suggestive of bacterial endocarditis. *Franklin Berman, M.D. and W. Proctor Harvey, M.D. Curable or Reversible Forms of Heart Disease. GP, March* 1956.

‹ ›

## Anorexia and nutrition

Anorexia resulting from congestion and medicines, weight reduction programs, and salt restriction all tend toward poor nutrition of the cardiac patient unless meticulous attention is given to providing an attractive, well balanced diet—often best divided into four to six small meals. *Chester W. Fairlie, M.D. The Liver in Congestive Heart Failure. Amer. Heart. A. Jan.* 1956.


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**Monmouth, Illinois**

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.

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[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

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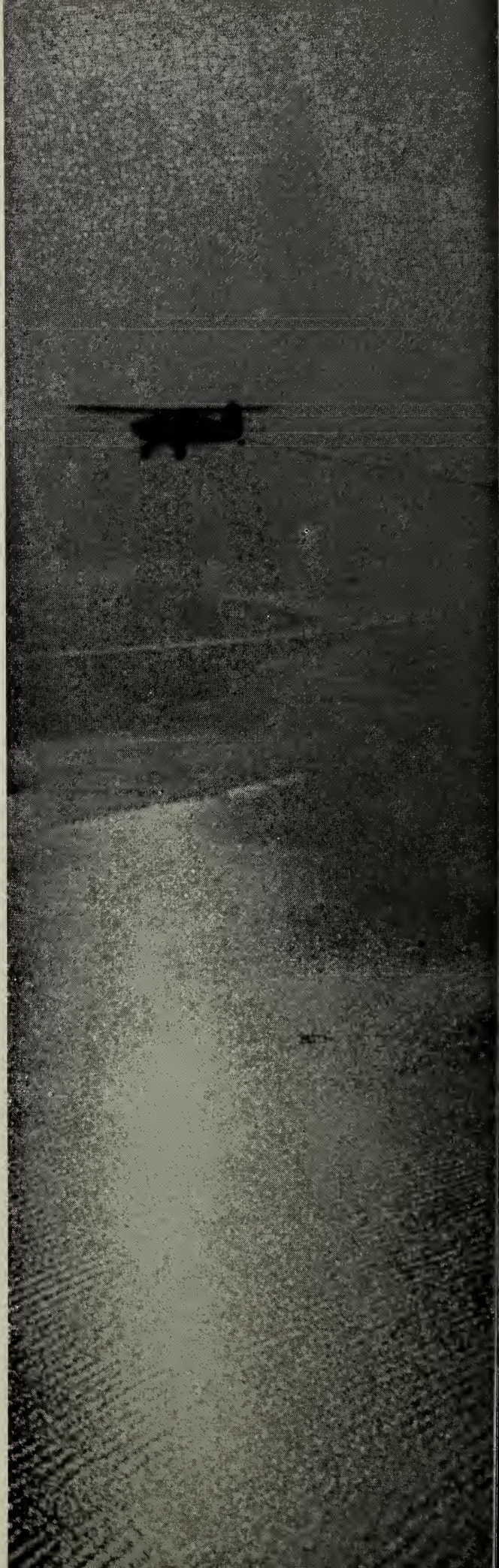
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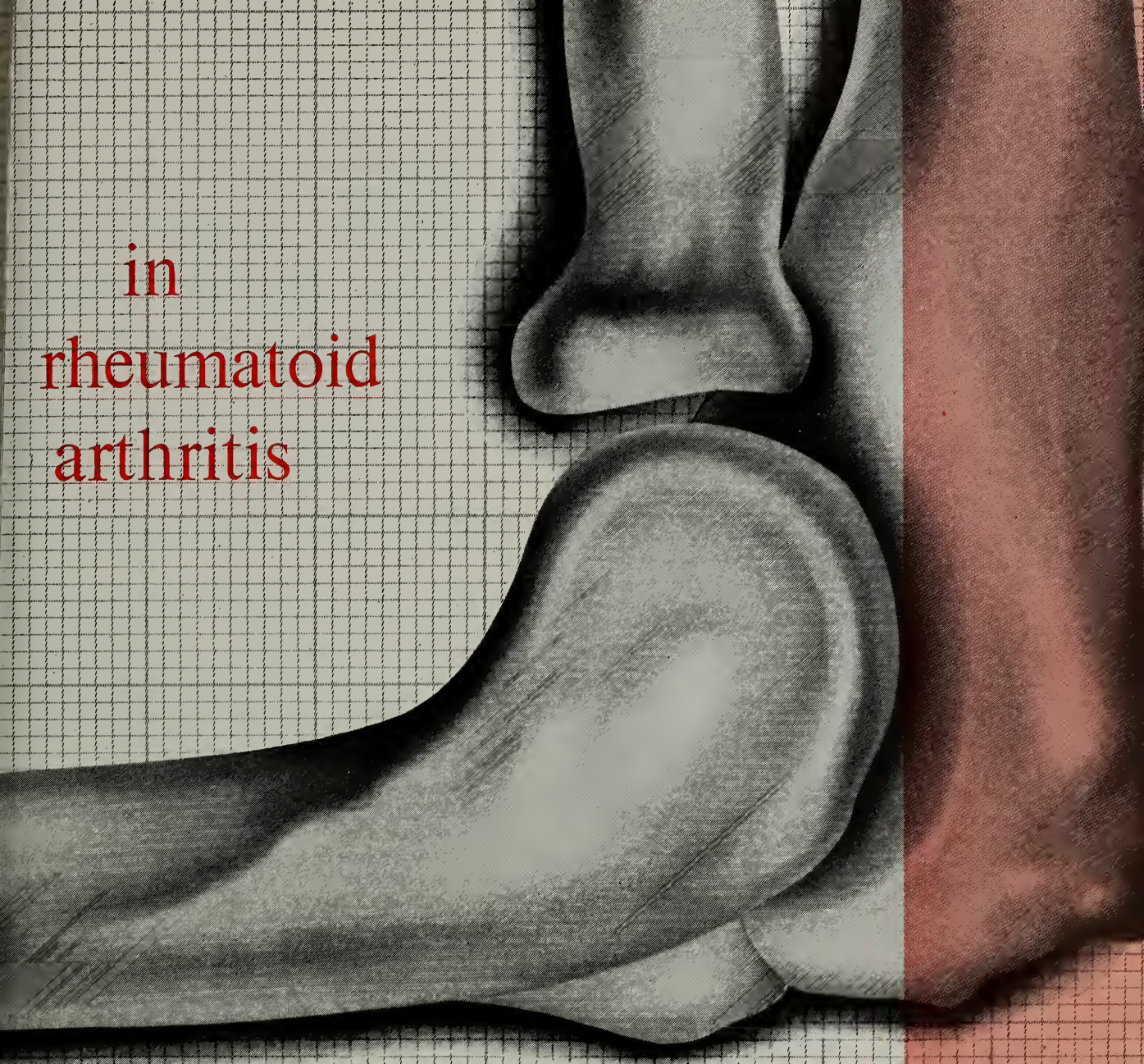
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## B12 in anemia

Pernicious anemia is a deficiency disease arising from the failure to absorb 1/1,000,000 of a gram of vitamin B12 daily from the gastrointestinal tract. This defect results in altered systemic cellular metabolism characterized clinically by a macrocytic anemia and gastrointestinal and central nervous system manifestations. When Minot and Murphy announced 25 years ago that pernicious anemia could be treated successfully with whole liver, this disease was removed from the category of uniformly fatal refractory anemias. In the therapy of pernicious anemia, we have a potent specific factor, vitamin B-12. Transfusion of blood still is important when the degree of anemia is sufficient to produce cardiac insufficiency and, in general, is to be considered when the red blood count is below 1,000,000 cells per cu. mm. Usually 15 micrograms are given each day intramuscularly for one week and twice weekly until full hematological remission is obtained. Aerosol inhalation of crystalline vitamin B12 can be demonstrated to produce complete hematologieal responsc in pernicious anemia patients. Similar responses result from the inhalation or nasal insufflation of vitamin B12 lactose powder. A single application of 150 micrograms of B12 crystals on the nasal turbinate mucosa gave a complete remission lasting for three months. In addition to the resolution of the anemia we encountered complete relief from gastrointestinal symptoms and improvement in the neurologieal manifestations comparable to parenteral therapy. *Abstracted by Henry Ford Hosp. Med. Bull, Dec.* 1955 *from J. Michigan M. Soc.* 54: 1101, 1955.

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Methods have not yet been devised for preventing the occurrence in susceptible human beings of frank, clinical illness following infection by the tubercle bacillus. Tuberculosis continues to be passed from the sick to the well, and new cases of active and probably active disease are reported at the rate of approximately 10 per hour or 84,000 per year in the United States and territories. Annual Rep., Div. of Special Health Services, U. S. Depart. of Health, Ed., and Welfare, Wash., D. C. 1954-1955.



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## Premenstrual depression

This syndrome probably is related etiologically to the much publicized premenstrual tension. It is characterized by the development of lethargy, headache, disinterest, and water retention and occurs four or five days before the onset of the menstrual flow. Smith has suggested absorption of endometrial catabolites with extracellular accumulation of sodium as a possible cause. Whereas certain subjects respond in a hyperirritable fashion, with excessive overt activity, temper tantrums, and insomnia, others seem to enter a depressed phase. The latter group, it was thought, might respond well to pipradrol. Fifteen women who presented such complaints were given 1 mg. three times daily, therapy beginning one week before the onset of menstruation. Nine noted appreciable improvement, three described some increased interest during the period of treatment, and three were unchanged. It is interesting that the three patients who were unaffected by pipradrol also were not helped by amphetamines, salt restriction, or diuretics, *Robert W. Kistner, M.D. and Christopher J. Duncan, M.D. Use of Pipradrol in Obstetrics and Gynecology. New England J. Med. March* 15, 1956.

## Adrenal tumor

A pheochromocytoma is a functioning tumor of chromaffin tissue which usually arises in the adrenal medulla. Since chromaffin cells secrete epinephrine and nor-epinephrine, the tumors characteristically produce hypertension which may be paroxysmal or sustained. Although the tumors are rare in children, they should be considered in the differential diagnosis of any hypertensive child because they represent a curable form of hypertension. Delay in diagnosis steadily increases the jeopardy of the patient. *Bernard J. Spencer, M.D. et al. Pheochromocytoma in a 7-Year-Old Girl. Minnesota Med. April* 1956.

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Modern treatment has not simplified the management of tuberculosis. There is need for clinical judgment and experience in applying established principles to the needs of individual patients with this protean disease. This is especially true of the many types of extrapulmonary tuberculosis, most of which are susceptible to the chemotherapeutic approach. R. Corwin Hinshaw, M.D., J.A.M.A., July 9, 1955.


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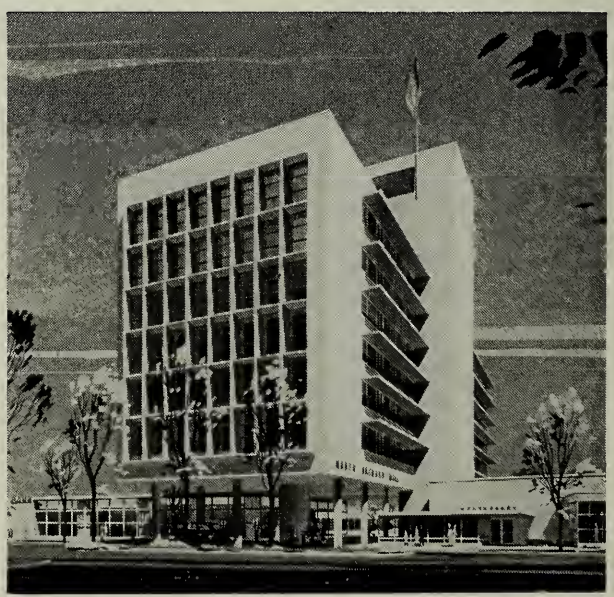
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Official Journal of The Illinois State Medical Society

JULY, 1956
VOL. 110 NO. 1

# The Immediate Care of the Postpartum Patient

WILLIAM BENBOW THOMPSON, M.D., LOS ANGELES, CALIFORNIA

ATTENTION to the postpartum patient does not begin with the delivery of the placenta or even with the birth of the baby, but far antedates these events. One of my gynecological colleagues from San Francisco has said facetiously that an adolescent girl having her first period should be considered a premenopausal patient. With much more justification, it may be stated that postpartum care begins with the first visit of the patient to her obstetrician, since the aim of all prenatal service is directed to the end that there may be a puerperium unmarred by distresses and diseases that might have been avoided. This discussion is not to be so all-inclusive. It shall be limited somewhat to the immediate period following childbirth, although pointing out attentions and precautions that must be observed prior to actual delivery. The baby is included in the discussion, for at the time our patient becomes postpartum we have two patients, not one.

Probably the least employed aid to baby's initial well being is the preservation of a full complement of the baby's own blood. Many years ago, it was shown there was a gain of one to three ounces in weight if the baby's cord was not clamped until it had ceased pulsation, and that if the baby were held lower than the uterus, this weight gain increased somewhat. The gain represented placental and cord blood belonging to the baby, and in the interval between birth and constriction of the umbilical arteries, compression of the placenta by the contracted uterus would squeeze out the blood in the placental circulation. Gravity flow was secured by lowering the baby. McCausland and his co-workers[1] showed that the same result could be obtained by immediate gentle stripping of the cord toward the umbilicus, and that babies so treated showed less initial weight loss, less icterus, and better general behavior than control babies with prompt clamping of the cord. The amount of extra blood so conserved is not small. At one time when we were debating whether our blood bank could not profitably use placental blood, a number of us measured blood as it flowed from the umbilical vein after early cutting of the cord. The range was from 35 to 135 cc., sufficient for a transfusion to a newborn.

Our first concern at the time of delivery usually is the condition of the baby. He arrives, and all attention centers upon him. Until he breathes, cries, and shows that he is now an individual in his own right, he is a worrisome thing. Has his oxygen tension been dangerously lowered these last hours or minutes of intrauterine life? Mengert[2] has pointed out that the weight of the

*Presented before Section on Obstetrics & Gynecology, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

pregnant uterus on the inferior vena cava may cause a dangerous drop in blood pressure and even placental separation, so that the patient should not be left for long in a supine position. His observation is the only one I know of that would give any scientific basis for the English custom of delivering patients in a modified Sims' position. There also may be dangerous drops in pressure following the administration of spinal or caudal anesthesia, so that frequent blood pressure readings and close observation of fetal heart rate and rhythm are imperative lest a bereaved mother must be told that the anesthetic agent, selected because "it would not put the baby to sleep", did exactly that on a permanent basis by depriving it of a constant flow of oxygen. When regional block anesthesia is employed, additional oxygen to the mother while she is in the delivery room is easily administered and the newborn will be able to accustom himself earlier to a new source of supply for his oxygen needs.

An occasional baby will be born that is not lobster pink and lusty. This may result from many factors, such as oversedation, prolonged anesthesia, or the physical difficulties encountered in delivery. Regardless of cause there is urgent need for increased oxygenation. How best may it be secured? I have little faith and less patience with the resuscitation machines currently manufactured. Some are demonstrated to show how a balloon, held tightly in one's fist, gradually expands in spite of the pressure upon it. What I cannot easily accept is the ability of the machine to select, as the test balloon, the tracheal passage and bronchial tree rather than the more easily available stomach, a true balloon with very low oxygen absorbing powers. Another apparatus, the Air-Lock, employs alternating waves of pressure analagous to the antenatal pressures exerted by uterine contractions. It may be, as Tollefson[3] suggests, that fetal respirations are preconditioned by these variations in pressures, and it certainly is true that some babies attempt to breathe in utero. Until the fluid they have aspirated is removed, they are in danger of drowning in their own amniotic waters. The only advantage I can see in the Air-Lock is that the babe is protected from overenthusiastic handling and mauling, and that its body heat is not dangerously lowered. My ire is more aroused, however, by the mechanical rather than the physiological defects commonly experienced. The machine isn't easily hauled in from the storeroom. No one knows which valves to turn or how far. The oxygen tank has leaked down to empty. Everyone is trying to serve the machine while the baby's chances of survival are getting less and less. This may be the machine age but thus far no machine runs without brains behind it, and none is able to explain to a flurried physician and house staff just how it should work.

Much the simplest method of supplying oxygen directly to the deeper air passages is that secured by an intratracheal catheter. This can be done by direct vision, using an infant size laryngoscope, or by digital guidance. I find the latter more rapid at a time when minutes count. Tracheal catheters are kept in our delivery rooms, instantly available. Thirty seconds should be all that is needed from the time one decides to employ this resuscitory measure until the catheter is in the trachea, and either gentle breath pressure or oxygen is flowing into that tube. Long ago DeLee stated, and it is still true, that not over 30 mm. of mercury pressure may be used safely.

Fluids may be aspirated, but the amount often is surprisingly small even in a baby that one would classify as "wet". A trap may be used to avoid the unpleasant taste of mucus and amniotic fluid that have filled the trachea at least partially, or one may aspirate into the catheter, remove it, and blow out the offending material, and reinsert it all in a few seconds. Oxygen should be given by an inflated rubber bag, and never connected to a tank with bubble-controlled flow. One can hardly exceed 30 mm. pressure from the cannula of the connector piece from the bag, while the bubbler has tremendous pressure behind it and can rapidly build up to dangerous levels. Provided the babe is only apnoic and not actually dead, it usually will begin primary respirations within one or two minutes. Rapidly the excursions will deepen, and then crying will be attempted; he is soundless since his vocal cords are held apart. At this point the baby is safe from the danger of anoxia. He may be left with the catheter in place, and one can watch with satisfaction how the bag of oxygen is now a rebreathing bag, flattening and swelling with each inspiration and expiration. Presently the baby will himself push the cathether out with his tongue, and then follows that most welcome

sound — the first cry of the newborn.

There is one objection to tracheal catheterization that is just as valid as the one applied to resuscitators. Neither will work unless someone is trained to employ the device. Since the charge nurse on each delivery room shift is the most constant attendant, she probably is the best candidate for instruction. Furthermore, her fingers are small, and better fitted to probe into the small space of the pharynx. Gentleness is a prerequisite. Once the landmarks are identified, the catheter slips easily into the trachea. Not more than another inch would be inserted, for the trachea is a short structure. For training, one of my friends uses the excised trachea and larynx of a lamb, and blindfolds those he would teach until they can identify the cartilaginous arytenoid promontories. The next step, and this is the only one I use, is a recent stillborn. No such unfortunate babe should be sent from the delivery suite without being used to demonstrate and practice tracheal intubation. If one waits until he is in trouble before he tries his hand he probably will remain where he began, in deep trouble.

But, strictly speaking, it is the parturient herself who is the postpartum patient. What attention to her in the first critical hour or so of her new motherhood will assist her in regaining strength and continuing in health?

First in the list of these measures is to take steps to prevent excessive blood loss or to replace such loss if preventive measures prove insufficient or ineffective. Hemorrhage more often occurs in patients whose uteri are overdistended, whether by multiple pregnancy or hydamnios; in those whose labors have been unduly prolonged, so that uterine tone has been dissipated, or precipitate, where the uterus may not have become accustomed to a tonic state of contraction; and in those who tend to bleed unduly. Red-haired women are said to be in this last category. Whether this be fact or fable I do not know, but with such patients, as in the others enumerated, I place an 18 or 19 gauge needle in an arm vein and keep it open with salt solution or 5 per cent glucose until I am reasonably certain that transfusion will not be needed. It is far easier to insert such a needle before the vein selected has collapsed and contracted. I shall not dwell upon blood replacement, save to note two rules that have served me satisfactorily. The first is: If I would order a transfusion for a patient at the County Hospital, where blood is freely obtainable, then I order it for my private patient. She deserves as good treatment as her sister patient in the charity ward. The second rule is: Sufficient blood is given to replace the estimated loss, and if there be doubt as to quantity, an extra pint.

Reduction in the amount of blood loss may be secured by early administration of any oxytoic. Either one of the ergonovine series or pituitary extract may be used. My preference is for pitocin, given intravenously with the delivery of the baby's shoulders. The effect is prompt. Usually my nurse assistant has expressed the placenta and redraped the patient by the time I have dressed the baby's cord and affixed its identification necklace. In five or six per cent, however, the cervix also tightens, and clamps down to a diameter of three or four cm., thus effectively trapping the placenta within the fundal cavity. The advantage of using pitocin rather than one of the ergonovine series, which gives the same incidence of retained placentae, is that its action is shorter. In 15 to 20 minutes it is possible to remove the placenta. I see no reason for observing the rules of former days that required at least an hour of waiting (provided there was not accompanying hemorrhage), and of repeated pounding of the abdominal wall which was known as attempted Crede expression. Before manual removal, I first change gown and gloves regardless of whether I consider myself clean or not. Were I completely logical, which I am not, I would order an antibiotic for all patients in whom I have invaded the uterus. Actually I am guided in that precautionary order by the length of time the patient has been in labor and the time her membranes have been ruptured.

With the patient now delivered, the baby in good condition, the placenta expressed, and no complications that demand immediate attention, I now inspect the cervix. Almost invariably lacerations will be found and usually these can and should be repaired. Using a suitable retractor (the Guttmann is satisfactory but narrow right-angled retractors which we know as Jackson's may be used if one has assistants) the cervix is grasped with sponge forceps, brought into clear view, and the area of laceration appraised. After trimming rough edges and oc-

casionally extending such trimming to include cystic diseased tissues, interrupted sutures of chromic catgut placed at about 1 cm. intervals approximate the raw surfaces. These sutures must, if they are to be effective, include the circumcervical fascia. For some reason, a better cosmetic effect is secured if the uppermost suture starts above the angle of denundation, swings down to the angle, and up again to the level of the point of entrance. This suture then is tied above the line of incision. The lowermost suture should approximate the junction of squamous and columnar epithelium.

Cervical tissues are somewhat friable and tensions must be avoided sedulously. I prefer an atraumatic suture with #1 catgut to avoid increasing the diameter of the needle puncture by following its course with a doubled suture, and a suture of sufficient diameter to bear upon the soft tissues involved without cutting out as placed. Actually, a 5-0 suture would have sufficient tensile strength and that fact should be borne in mind while tying the sutures.

What is gained by repairing lacerations that do not, by bleeding, indiciate any need for attention? Enough, I think, to make it worthwhile. At least three out of four such repairs hold and heal well. A surprising number show at six week examinations, an external os resembling that of a nullipara. So rarely do I find need for cervical cautery that my outfit grows dusty. The incidence of chronic cervicitis, that bane of mothers, is vastly reduced. Even the ones not benefited at all, which I would guess to be 10 per cent, are no worse off than if the attempt had not been made. I have followed this procedure for more than 20 years and am sure that I will continue to the end of the chapter. It takes only 10 to 12 minutes, costs the patient nothing, and does not lengthen the hospital stay or convalescence. I have done cervical repairs three, four, and five times on quite a few patients and have never noted any stenosis of the cervical canal subsequent to repeated repairs. Only two cautions need be noted. Occasionally it is difficult to expose the cervix. It should not require much force to bring it into view, and if more be required, one will be wiser to restrain his curiosity and his strong right arm. An extremely thinned out cervix may be found with a cross section about as thick as a folder blotter. Sutures probably will not hold and repairs will be unsatisfactory if done immediately.

If there be anything new in this procedure for which my associate, Dr. Emil J. Krahulik, and I are responsible, it is only in two minor points. One I have mentioned, in the placing of the uppermost suture. The second is that in trimming the angle of laceration, one cuts somewhat on the bias, so as to leave the repaired cervix with the diameter of the canal in proper proportion to the diameter of the entire cervix.

I might add that pathological examination of cervical trimmings was begun in 1947 by Dr. Maurice V. Sheets[4,5] at that time resident in obstetrics at the Hollywood Presbyterian Hospital, and continued by him as time permitted. He now has examined carefully over 1,300 specimens. Two of these showed early invasive carcinoma, while three, and a fourth questionably, have been classed as carcinoma-in-situ. Eighty-three had aberrations of basilar architecture that may prove significant. Follow-up of patients with basal cell changes is difficult but we hope to carry it out long enough to indicate whether these are the women who will come in significant numbers to our cancer clinics in later years. Hence, I urge that if you essay this repair the co-operation of your pathologist be secured, and that your findings be correlated with those of Doctor Sheets.

Finally comes the restoration of the perineum. For some reason, this task often is neglected. Too many seem to feel that because it will again come under the scrutiny with the birth of the next baby in the family, it is hardly worthwhile to do a careful repair at this particular time. This is indeed a poor excuse. Upon the integrity of her pelvic floor depends the ability of a wife and mother to perform the multitude of tasks that come her way. Poor repair work is followed by the complaint that the patient feels constantly a weight in her pelvis which actually is true. Vaginal mucosa left exposed becomes irritated. If buried in the wound, inclusion cysts form and continue to grow until enucleated. External skin, folded into the vaginal canal, exfoliates rapidly and also becomes irritated. Dead space in the repair fills with fibrous tissue, more difficult both to repair and to heal if again this woman returns to the delivery table. These tissues were originally in an excellent pattern

and we would do well to restore them to their former relationship.

I shall not detail to you the technique I employ in repair save in two small matters. I use two Allis clamps to grasp the fourchette a half inch or so from the upper edge of the episiotomy wound, rather than use any of the butterfly retractors that are among the instruments. Tension is then lessened by the assistant as the repair progresses, and at no time am I opposing the spread of the retractor with the tightness of a suture. I can, therefore, use light suture material. Gradually I have come to 3-0 chromic, and even with this, avoiding tying sutures too tightly. I am plagued, as you are, by the patient who wishes to know how many stitches she had. There seems to be some kind of a contest as to which woman can claim the most, and while at times I suggest that she think of a number from four to forty, more often I merely say "enough so that you will stay together". If a lot of dead spaces are left, infections and breaking down of repairs will be frequent even with wire sutures. Careful anatomical repair, with few and small dead spaces, will heal with fine suture material. A good repair means less immediate discomfort and less trouble in the future.


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## Abdominal epilepsy

It is difficult to discuss "abdominal epilepsy" without defining "epilepsy," the undefinable. Our remarks are confined to an alleged association between recurrent abdominal pain and epilepsy. Our conclusions are based on the premise that a group of children with epilepsy shows a significantly higher proportion of characteristically abnormal EEGs than does a group of nonepileptics.

In all four groups of children — hospital and school children, with or without recurrent abdominal pains — the distribution of abdominal EEGs was similar. The comparative figures are substantially unaffected, whether resting and/or evoked records are considered. The similarity between the four groups suggests that EEG abnormalities and recurrent abdominal pains are not associated or inherently related.

We infer that the suggested causal relationship between abdominal pains and cerebral dysrhythmia may be based on: a failure to compare EEGs with those of apparently normal children of similar ages and attainments; and a consequent acceptance of EEG variants as indicative of epilepsy. *John Apley, M.D. and June K. Lloyd, M.B. Electro-Encephalography in Children with Recurrent Abdominal Pain. Lancet. February* 11, 1956.

# Trends in Varicose Vein Surgery

**Richard E. Heller, M.D., Chicago**

THE problem of the treatment of varicose veins is one that has vexed the physician for hundreds of years and led to a never ending variety of therapy. In the beginning, rather simple procedures were used and as these failed to cure the condition other more radical and more complex forms of therapy were tried. As this trend progressed, there occurred an increasing frequency of complications, which finally became so numerous and severe that radical therapy was discarded and then there was a return to simpler procedures. In the last one hundred years there have occurred two such cycles each ranging from injection therapy to ligation, then to a combination of ligation and injection, and finally to radical dissection and division of varices.

The first radical period was from about 1880 to 1915, during which the Schede operation and the stripping procedures of Keller, Mayo and Babcock were tried and discarded because of a high incidence of complications. Then with the development of new sclerosing solutions of the fatty-acid type, another cycle was started and now has reached the final turn with the increased popularity of sapheno-femoral ligation plus either multiple division or complete removal of varicose channels.

This repetition of therapeutic trends indicates that no wholly satisfactory treatment has yet been devised. Research has, however, brought to light basic information concerning the anatomy, physiology, and pathology involved and there is now a better understanding of both the causes for failure and the factors essential to a satisfactory form of therapy. It might be well to summarize the major reasons for failure so as to point out the rationale for the present vogue of radical surgery.

The injection treatment, popular over a long period of years, is based upon the production of a chemical inflammation of the intima and subsequent thrombosis of the vein. This fails to give permanent results because the clot tends to become recanalized and absorbed and the intima of the vein to heal over. Moreover, if valvular incompetence is present proximal to the site of thrombosis, the occluded segment will be subjected to sudden pressure surges when the patient coughs or strains and this will increase the speed and frequency of recanalization. The use of sclerosing solutions may be associated with such complications as allergic reactions, periphlebitis, pigmentation of the skin, local sloughs, deep venous thrombosis and pulmonary embolism. A high recurrence rate plus the danger of these unpleasant side reactions has made sclerosing therapy lose favor as a primary form of treatment. It is now advocated mainly as a supplement after surgical intervention.

Early surgery consisted of ligation and division of varicose veins in the thigh some distance below the fossa ovale. This was not successful because of the peculiarities in arrangement of the superficial veins. Anatomical studies have shown that there are wide variations in the arrangement, numbers and connections of the trunks and tributaries of the long and short saphenous systems. These channels anastomose freely, and easily form shunts around any site where the veins are divided. The presence of incompetent valves and back pressure near the site of division will place an extra load on collaterals so that they will rapidly dilate and form a by-pass.

Incompetence is present most often in the long saphenous trunks where valves at or near the sapheno-femoral junction may be congenitally absent, destroyed by inflammation, or relatively incompetent due to dilatation of the vein wall so that cusps cannot become opposed. With recognition of this, it was suggested that recurrences could be prevented by ligation and division of the long saphenous at the point where it empties into the common femoral vein. This would eliminate the site of origin of the incompetence. This operation became popular between

*Presented before the General Assembly, 111th Annual Meeting, Illinois State Medical Society, Chicago.*

about 1930 and 1940 and was used by some surgeons in combination with a retrograde injection of sclerosing solution to make certain that the major trunk was completely thrombosed. Some days following the operation further injections were given to obliterate any remaining varicosities.

In the next few years, the results of the combined technique were assayed and a very disturbing recurrence rate noted. Most failures were found to be due to dividing the trunk of the saphenous not at its termination but a few millimeters below, where the small tributaries enter. These tributaries too, are able to dilate and short-circuit the site of ligation. Surgery was then extended to insure the proper site of ligation and complete division of all tributaries. With this the procedure became more satisfactory though recurrences still plagued the surgeon.

Continued investigation has showed that some failures are due to incompetent short saphenous or perforating veins. When these channels become incompetent there are again present pressure changes which traumatize the superficial vessels and lead to varicose vein formation or nullify treatment. Further surgical procedures are necessary to interrupt this action.

Since the long saphenous system of veins is usually involved and in most cases found incompetent, the cornerstone of modern treatment is ligation and division of the long saphenous trunk at the point where it joins the common femoral. The procedure must include actual ligation at the junction, and division of all tributaries which enter at or near the termination. After this, there remains the disposition of the distal trunk and lower tributaries, the short saphenous and the perforators. Opinions differ as to the best form of treatment and at present, the involved channels are being disposed of by multiple ligation, stripping, complete excision, or a combination of these.

Multiple ligation consists of interrupting the saphenous at intervals along the major trunk and where perforators and communicating veins join it. Using procaine infiltration anesthesia, multiple small incisions are made, the vein dissected free, doubly ligated at the ends of the wound and the intervening portion excised. This produces a segmental interruption of the veins and frequently results in thrombosis of the channels between the points of division. The operation is associated with very little morbidity, the average hospital stay being two to three days. One week after surgery any varicosities which are still patent are injected with a sclerosing solution.

The advantages of the multiple ligation operation are that it is easy to do, has a low morbidity, few complications and a fair cosmetic result. It has the disadvantage of a fairly high recurrence rate due to either recanalization and formation of an anastomotic network around the sites of division or the presence of overlooked incompetent perforating veins.

Vein stripping represents a more radical procedure in that after the high saphenous ligation the distal saphenous trunk is actually stripped out of its bed, in most cases from the groin down to the ankle. This is accomplished with the Mayo or Meyer type of stripper. The operation is usually performed under spinal, or combined local procaine infiltration and pentothal anesthesia, the procaine infiltration being used for all dissections and pentothal for the actual stripping process. Before removal of the veins, the operating table is tilted into the Trendelenburg position to empty the vessels and reduce bleeding. After stripping, the incisions are closed and then compression bandages applied to prevent hematoma formation. The patient is ambulatory in 12 to 24 hours and out of the hospital in 4 to 5 days. After about two weeks, any remaining patent varicosities may be injected.

Stripping of the long saphenous is easy to do, and has a fairly low morbidity. The cosmetic result is the most satisfactory obtained by present methods. The disadvantages are that it is followed by recurrences in residual veins because it does not ordinarily include removal of all the incompetent perforators.

The most radical operation is that of direct excision of all dilated channels. This requires a general or spinal anesthetic and with extensive incisions one may actually visualize all the involved vessels. Because of the extensiveness of the operation there is an increased morbidity and the hospital stay may be prolonged to a week or more.

Vein excision permits a direct attack on all varicose channels and theoretically at least

should yield the highest per cent of cure. Practically however, the recurrence rate appears to be almost as high as that found with stripping due to the inherent difficulties in completely dissecting out all involved channels. The extensive incisions tend to heal slowly and often produce a poor cosmetic result.

The intrinsic advantages of stripping of the long saphenous trunk seem to make it the most popular of present day operations. However, in order to eliminate all possible sources of reflux one step more is being added—that of direct interruption and excision of stripping of all tributary varices connecting with incompetent short saphenous or perforator channels. The morbidity, while greater than with simpler methods, is relatively slight and complications are few in number and severity. Stripping has been found much safer than when first used at the turn of the century because of better pre- and post-operative care, the use of early ambulation, and better surgical technique.

To summarize, failure to obtain cures is due to the following:

1. The ineffectiveness of chemically induced thrombosis.
2. The presence of tributaries which are able to dilate and short-circuit the obliterated channel.
3. The presence of incompetent vessels which allow abnormal blood flow and stimulate varicose vein formation.
4. Finally, the development of varicose veins, in some cases, appears to be a progressive disease and new channels become involved in spite of the best treatment.

Therapy must take into consideration two basic principals: varicose veins must be disconnected from the rest of the superficial veins in some way that will *permanently* prevent a flow of blood through them; and secondly *all sites of reflux*—the sapheno-femoral junction, the short saphenous and popliteal, or perforating channels in the thigh and leg—must be permanently obliterated. It is evident that these principles, of necessity, require an increase in the magnitude of surgery. We have here the basis for the radical trend in present day therapy.

With recognition of the importance of the elimination of all channels containing incompetent valves, a variety of methods have been developed to aid in the locating of sites of incompetence. The Brodie-Trendelenburg and Ochsner-Mahorner tests have been of value in surveying the general status of the veins but are not sensitive enough to indicate channels having border-line incompetence or those so weakened that incompetence will subsequently develop.

Venography with X-ray opaque media has been used to locate incompetent perforators and appears to be of some value though the interpretation of films may be difficult and the use of opaque media occasionally is associated with allergic reactions. The technique is perhaps of most value in the locating of incompetent perforators in cases having recurrence after operation.

The limitations of such tests has reduced their usefulness and experience with large series of patients has shown that when the long or short saphenous trunks or tributaries are distended, tense and tortuous, the valves are actually or relatively incompetent. In addition, the presence of incompetent perforating veins is usually marked by large aneurysmal dilatations. If one observes such changes, special tests are thought to be unnecessary. The treatment indicated is surgery.

The problem of the treatment of varicose veins developing after deep venous thromboses has recently been considered in a different light than in earlier years. In the past, it was felt that this type of varix developed as a collateral channel around a point of obstruction in the deep veins, and that obliterative therapy would increase edema and disability. It seems however, that after a deep thrombosis the actual obstruction is present only a short time, the clot being rapidly absorbed. The residual chronic effects appear due to the destruction of the deep valves by the inflammatory process. When varicose veins have developed and their valves become incompetent there is an added load on the already impaired circulation, and the obliteration of such varicosities will lighten the load and improve the condition of the leg. Therefore, if one finds incompetent varicosities that have developed after a deep venous thrombosis, operative treatment is recommended.

In conclusion, it appears that with the increasing knowledge of the pathology of varicose veins, only one form of therapy—radical surgery—is effective. Surgery is advocated for all varicose veins except small segmental dilatations

that have been present for some time and show little tendency to extend. This point of view represents the extreme in the present cycle of therapy and it is unlikely that there will be a return to less radical measures until some completely new form of treatment is developed.

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# Abdominal Pain: Its Interpretation in the Diagnosis and Management of the Acute Abdomen

**Gerald J. Menaker, M.D., Chicago**

A BETTER understanding of the mechanisms of abdominal pains and their relationship to the clinical symptoms and findings, as well as their interpretation in the diagnosis and differential diagnosis of the acute abdomen, is the objective of this paper.

Proper evaluation of painful stimuli is easier if one is cognizant of the patient's habit pattern of reaction to painful stimuli — the pain threshold. It is more difficult when, unlike the family physician who has known the patient all his life, a physician sees a patient for the first time. Attention must be given also to factors that influence the pain threshold, such as anticipation or inflammation which lowers the threshold; the release of adrenalin, distraction, or hypnosis which may increase the pain threshold.

In this paper, we are most concerned with pain of visceral origin, which is conveyed by the splanchnic nerves. The viscera have the same type of nerve fibers found in the skin but they are fewer in number and are conditioned to stimuli different from those commonly applied to the skin. The intestine or stomach can be cut, clamped, or burned without pain, as we have so often witnessed in the opening of a colostomy without benefit of anesthesia. Stretching, contraction, or distention — stimuli to which the viscera are conditioned — will send impulses along the sympathetic pathways and produce pain. Rapid abnormal stretching of the capsule of solid organs such as the liver, spleen, or pancreas will produce pain as will sudden anoxia of visceral musculature. Visceral pain is notably dull or aching and, as the viscera are not subject to external injury, these pains are poorly localized because of the individual's lack of past experience. The physician has the greatest difficulty in interpretation of this type of pain. In addition, the patient's threshold for pain must be known because there usually are few or no objective findings at this stage of the disease in contrast to the objective findings accompanying parietal or somatic pain.

## MECHANISMS FOR VISCERAL PAIN

There are essentially three mechanisms for visceral pain:

*True visceral pain,* which is caused by an adequate stimulus such as distention or contraction of a hollow viscus. These pain impulses are carried by the sympathetic nerves and usually are poorly localized, diffuse, deep, and often situated in the midline probably due to mesen-

teric attachments. They often are associated with nausea, vomiting, sweating, a fall in blood pressure, and slowing of the pulse. Examples are the pains associated with so-called spastic colon due to abnormal contractions of the colon; early pains of acute appendicitis due to obstruction and/or distention of the appendix; or early pains of bowel obstruction. Rapid abnormal stretching of the capsule of solid visceral organs such as the liver, spleen, or ovary, as for example by hemorrhage into these organs, will result in this type of pain.

*Referred visceral pain* stimuli are carried by both the sympathetic and cerebrospinal nerves through the communication of these nerves. Afferent impulses initiated in the viscus, via the sympathetics, are referred to areas supplied by somatic nerves of the same segment of the cord and have the same segmental distribution as the point of stimulation. Stimulation of a deep structure gives referred pain, whereas stimulation of a superficial structure by the same stimulus gives local pain. A brief weak stimulus also gives rise to local pain while a sustained or intense stimulus often results in a more diffuse, widespread, or referred pain, segmental in type. An example of this mechanism is the pain referred to the scapula in gall bladder disease.

*Parietal pain* is the third mechanism of visceral pain, its perception being through the cerebrospinal nerve endings which are present in or just beneath the parietal peritoneum. Some of these fibers may extend into the posterior parietes or the root of the mesentery. These pains are sharper, stabbing, better localized, and more closely related to the site of the diseased organ. They are somatic pains and result in cutaneous tenderness, hyperalgesia, hyperesthesia, and muscular rigidity. These pains are aggravated by walking, coughing, or the auto ride to the hospital. If the stimulus is maintained for a long time, a sustained muscular contraction may remain after the original pain subsides. Such spasm may in turn initiate noxious stimuli and re-excite pain. This is the mechanism for pain, tenderness, and rigidity in the suppurative phase of acute appendicitis with localized peritonitis or inflammation of the parietal peritoneum in the area of the appendix. Somatic pains may be referred as, for example, when the diaphragmatic pleura or peritoneum is involved and pain is referred to the root of the neck or shoulder.

In effect, acute abdominal pains occur in two phases or stages. First, the visceral phase which produces a protopathic or deep, indefinite, poorly localized pain, which is due to the lesion in the viscera itself or to dysfunction of the organ because of the presence of the lesion. Secondly, there is the peritoneal phase which produces a well localized, more superficial type of pain and is due to involvement of the parietal peritoneum. This phase tends to dominate the clinical picture and represents a late stage, often with serious complications. We must strive for early recognition of the disease process before the obvious peritoneal signs appear.

## FACTORS INFLUENCING PARIETAL PAIN

An understanding of the visceral attachments, reflections, recesses, and foramina is important in the interpretation of abdomial pain. Some anatomic facts of importance are as follows:

1. The peritoneum has an extraordinarily rich supply of blood vessels, lymphatics, and nerves.
2. The peritoneal cavity is a completely closed internal space except in the female where there is an external communication through the fallopian tubes.
3. Above the transverse colon lies the subphrenic space containing liver, gall bladder, duodenum, stomach, spleen, and pancreas.
4. The mesenteric attachment of the small intestine is on an irregularly curved line from the upper left to the lower right quadrant, dividing the infracolic space into two spaces, the right terminating in the right iliac fossa, the left passing uninterruptedly into the true pelvis.
5. Two lateral spaces lie lateral to the ascending colon. These are known as lumbar gutters.

These anatomic facts are most important in understanding the localization of inflammatory processes. It is easier to understand the frequent localization of pain and tenderness in the lower right quadrant after perforation of a duodenal ulcer, the localization of a pancreatic process to the lesser peritoneal space or the subhepatic or subphrenic location of pain, or abscess following perforation of ulcer or a chronically diseased gall bladder.

Interesting and important physiologic factors are as follows:

A. Contents of the stomach and duodenum are highly acid and proteolytic and these secretions are shockingly irritative to the parietes even though not of high bacterial content except immediately after a meal.
B. Bile is less irritative and usually is sterile unless previously infected as in empyema of the gall bladder.
C. The contents of the structures arising from the midgut are liquid and relatively low in bacterial count until one reaches the ileum or ascending and transverse colon.
D. The contents of the descending colon tend to be formed and have a high bacterial content.
E. Blood is irritative to the peritoneum, though less so than gastric contents, and will set up noxious stimuli and somatic pain.

Let us consider, the case of the perforated duodenal ulcer. The first pains often are epigastric and typically visceral or sympathetic in transmission and may be more severe than the usual ulcer pain. These pains may be present for days prior to perforation. With perforation they become somatic in character, being excruciatingly severe because of the spill of gastric and duodenal content which markedly irritates the overlying parietal peritoneum. Marked tenderness and rigidity come on and the patient is afebrile, often subnormal in temperature. The abdomen is silent. Within a relatively short time pain, tenderness and rigidity may be found in the lower right quadrant due to spill and diversion by the peritoneal reflections of the spillage to this part of the abdomen. In untreated cases, depending upon the bacterial content of the spillage, fever usually is a late finding. Untreated cases where the process is walled off by previous adhesions and attachments may result in subhepatic or subphrenic abscess.

In the diagnosis of the acute abdomen a thorough understanding of the various mechanisms of abdominal pain, a knowledge of anatomy and physiology, and physical examination often are all that is required. It is true that certain laboratory tests may be of value; however, these are only confirmatory, sometimes time consuming, and may be of definitive value only late in the disease. The diagnosis of the acute abdomen requires serious consideration of the history of the pain, including the type of onset, its nature and duration. Past illnesses or exposures may be factors in the present illness, such as chronic gall bladder disease, pneumonia, virus diseases, diabetes, or valvular heart disease. The presence of valvular heart disease may well influence the ultimate diagnosis of a sudden severe abdominal crisis.

Physical examination must include inspection, palpation, and auscultation. Inspection may demonstrate the presence of herpes zoster, petechia, or an umbilicus deformed by localized muscle spasm resulting from somatic pain. Palpation should be gentle and first begun away from the suspected site of tenderness, so as to eliminate voluntary muscle spasms. Palpation by rectum, vagina, and in the flank must never be omitted. The stethoscope is of great value in the interpretation of bowel sounds, vascular sounds, or succession splash. Chest, the extremities, and inguinal or femoral orifices must not be overlooked in the complete examination.

In the differential diagnosis of abdominal pain one must consider thoracic disease such as pneumonia, pleurisy, or coronary heart disease which may result in abdominal pain. The absence of peritoneal signs is most helpful in these conditions. Neurologic conditions such as diseases of the spinal cord and nerves as well as tabetic crises or hysteria must be considered. These pains often are more general and indefinite in their manifestations, especially with respect to muscle spasm and tenderness as compared with true peritoneal manifestations. In hysteria, distribution of pain may follow patterns that are obviously psychosomatic.

## CONCLUSION

An understanding of the various mechanisms of abdominal pain, a thorough knowledge of the anatomy and physiology of the abdominal viscera and peritoneum, a good history and a well conducted physical examination, are the keys to the diagnosis of abdominal pain. Evaluation in this light is helpful both in diagnosis and for indication for surgical intervention.

30 N. Michigan Ave.

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# Medical Aspects of Otitis Media

**Philip Rosenblum, M.D., Chicago**

OTITIS media still is one of the most frequent pediatric diseases encountered. A discussion of it with the otologists will help assess the information learned since the advent of the sulfa drugs and antibiotics; and help evaluate some of the opinions that prevail. Some pediatricians feel it can always be treated medically, while many otologists consider it a surgical disease. There are several aspects of the problem which require more unanimity of opinion, such as the use of myringotomy, local measures, and simple aspiration. While many of the complications of otitis media such as meningitis, thrombosis of the dural sinuses, and abscess of the brain are seen rarely now, they have not been eliminated entirely.

From a diagnostic standpoint, the development of the electric otoscope was a great help to the pediatrician. You are all aware of the difficulty of immobilizing infants and children at times. Much of the otoscope's value is lost on trying to remove wax from the canals by sharp instruments or toothpick swabs instead of irrigating the ears carefully in order not to produce hemorrhage or trauma. If a large speculum is used when first examining the ear, wax will not be pushed into the canal in front of the speculum. Then the ear can be irrigated if necessary. We make it a practice to irrigate the ears during routine office visits if the drums are not visible, so that when the child is sick they can be inspected easily.

The etiology of otitis media is no different today from what it formerly was, but the disease is less frequent because of earlier and better control of the inciting infections. Bacterial and viral respiratory infections, allergies, sinusitis, and hypertrophied tonsils and adenoids are the important predisposing causative factors. Infants and young children are more prone to otitis media, because the eustachian tubes are more horizontal and practically as large as in older children. In some families enlarged tonsils and adenoids are present from birth. In others, the postnasal space is small and, while the adenoids may not be large, they encroach upon the orifices of the eustachian tubes and predispose to ear infections. The active organisms are the usual E.N.T. variety, but since chemotherapy with antibiotics, there are more resistant strains of cocci, Bacillus pyocyaneus, and Hemophilus influenzae, which require culture for identification and sensitivity.

Diagnosis ordinarily is easy, but in the newborn, otitis media may be overlooked in a crying fretful infant because of the absence of fever, the presence of tortuous canals, or because a poorly immobilized infant may make inspection of the drum difficult. Sometimes otitis media follows T&A operations because the adenoids are poorly removed or lymphoid tissue about the eustachian orifices becomes hypertrophied to compensate for the removed tonsils and adenoids. Pharyngeal lymphoid tissue proliferates up to about 12 years of age, then diminishes gradually. That is why, when the adenoids are the principal offenders, it is often best to leave the tonsils in. Adenoidectomy alone is probably more often indicated than done.

For many years, we have used X-ray therapy in young children and infants to diminish the size of adenoids and tonsils in selected cases. Recently, Dr. Dwight Clark[1], suggested an association between X-ray therapy and thyroid cancer in children and adolescents. While more thyroid cancer in children and adolescents has been seen in recent years, nevertheless, in our experience with X-ray therapy of tonsils and adenoids in several hundred patients, the incidence is no greater in the irradiated than in the untreated. In a recent patient, a girl of 17 years with a

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thyroid cancer, no radiation had ever been given. But this form of treatment should be studied further, and we will have to be guided by the indications and by our own experience. We have found the results of irradiation quite satisfactory.

In medicine, opinions naturally vary from time to time. To digress for a moment, some of the younger men here probably don't know that in the "20's," Mariott's Clinic in St. Louis[2] was recommending mastoidectomy and sinus operations in undernourished and premature infants for diarrhea of undetermined origin, even when there wasn't any obvious evidence of recent otitis media or mastoid infection.

The therapeutic aspects of otitis media will require careful and unbiased consideration. Preventive measures are important. Educate the public that earache is a serious complaint, and that medical advice should be sought early. It also is necessary that the doctor recognize its dangers and respond promptly and thoroughly. There has been too much telephone advice: "Put drops in the ear," or "call me tomorrow." Improvement in the general health of the child, removal of enlarged diseased tonsils and adenoids, treatment of allergy, if present, proper attention to sinusitis, and adequate therapy of all upper respiratory infections are most important.

I feel that some of the various concepts and divergences of opinion as to the proper treatment of otitis media are due to differences in the type of practice, and to the special interests and abilities of different men and groups. Certainly in an exclusively clinic or hospital practice, one is more likely to see patients that have been neglected or improperly treated before entering; so one may be biased and evaluate the whole subject differently from one in private practice. Naturally, the incidence of complications in this group is larger than in private practice.

In our experience, the results of active therapy, when properly instituted-which means early and continued for at least 7 to 10 days or until the drum has returned to normal-usually will give excellent results. When seen early and thus treated with sulfas or antibiotics or both, most infections will subside without any trouble or complications. But many patients even when seen early, already have bulging tympani, and some even show loss of the landmarks. Myringotomy usually is indicated here. Cultures should be taken and sensitivity tests done, so that proper medication can be given. If myringotomy is not done, nose and throat cultures in the region of the eustachian orifices should be taken. However, these are not as satisfactory as after myringotomy. Some pediatricians feel that myringotomy is never necessary[3], but I am sure this is a mistaken idea as is the insistence on myringotomy in all cases[4,5].

Some even suggest a three week hospitalization for all patients.

There are many statistics of the presulfa and preantibiotic eras, showing that the incidence of mastoiditis and complications after myringotomy is much less, and certainly we know many drums never return completely to normal when myringotomy is not done. Many treated only medically retain serum and the drums are distended for weeks; some of these patients encounter impaired hearing later. Local[5] treatment with antibiotics seems of value in our experience. When children are subject to repeated otitis media, X-rays of the mastoids should be taken as it is known that cholesteatomas sometimes develop even when there has been apparently good recovery from previous attacks.

Even though the majority of the children, when seen early with acute otitis media, can be treated medically, nevertheless some require myringotomy or aspiration, and progress should be followed by both the pediatrician and the otologist for the best welfare of the patient.

I feel that it is only by a discussion such as this that the status of otitis media can be properly evaluated; perhaps the complications and many hearing difficulties can be avoided in the future.

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# Radiation Cataract

**David Shoch, M.D., Chicago**

THE term, radiation cataract, has long been used in ophthalmology and has been applied to any lens opacity attributable to radiant energy. A classic example is glassblowers' cataract which we now know is a thermal or heat produced cataract due to the absorption of infra-red rays by the lens. In recent years a totally different portion of the electromagnetic spectrum has been extensively investigated.

The electromagnetic spectrum consists of a variety of waves or particles whose origin generally is a sudden change or rearrangement of the elementary particles of an atom. That is, it is the result of the movement of electrons from one orbit to another in the atom or the result of collision of atoms with particles of great energy. Depending upon the type of atom and the energy of the collision, waves of different characteristics will be emitted, and these waves (or particles) can be classified according to their frequency — the number of peaks that pass a given point per unit time. Although this is the most satisfactory way of classifying radiation, traditionally the term wave length is used which describes the distance between peaks.

A phenomenal finding is that a very minute portion of this electromagnetic spectrum is visible to the human eye and, in keeping with the egocentricity of man, this spectrum was therefore originally divided into infra-red rays (below the visible) and ultraviolet rays (above the visible). We now know that electromagnetic radiation exists for an infinite distance on either side of this middle range. The first slide adapted from Duke-Elder[1] shows the extent of the electromagnetic spectrum. From the bottom up we see the long waves familiar to us from commercial radio and from diathermy apparatus, the infra-red waves, the visible range, the ultraviolet, and above this the short X-rays, gamma rays, etc. where the wave lengths begin to approach the geometrical size of atoms and subatomic particles. This last group of wave lengths has been called collectively ionizing radiation, since the rays either are composed of charged particles or are capable of producing charged particles on collision with the atoms of tissue.

The lesions produced by this ionizing radiation are what concern us today and more specifically the lesion produced in the lens of the eye. Although cataracts produced by X-rays were reported many years ago, experimental studies of this condition were infrequently found in the literature.

However, the whole field of ionizing radiation injury received intensive study after the explosion of the atomic bombs in Japan at the end of world war II[2,3]. Along with other tissues, the eyes came under investigation. These investigations consisted chiefly in the description of the cataracts found in survivors of the Hiroshima and Nagasaki bombings. In 1949 cataracts were found in a group of our own physicists who had inadvertently been exposed to their cyclotron beams[4,5]. The government immediately established a Committee on Radiation Cataracts under the auspices of the National Research Council, and projects were undertaken in many centers to unravel the problem of radiation cataract. Details of dosage, safety factors, and relative biological affectiveness of the various types of radiation were quickly established[6], but the problem of the mechanism of cataract formation was more elusive and is still not completely solved.

Generally it was felt that the problem in the lens could be treated much as radiation injuries anywhere. Three lines of investigation suggested themselves: 1) That the cataract was the result of toxic products produced by general body irradiation. 2)That there was a direct action on the cells of the lens. 3) That the lesion was the

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*Presented before the Section on Eye, Ear, Nose and Throat, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 17, 1955.*

result of injury to the highly susceptible vascular bed of the tissue.

In the lens, a rather special situation presented itself in this regard since it has no blood vessels and one would have to postulate an injury to the supporting structures which nourish it, chiefly the ciliary body.

The local effect of generalized irradiation was quickly eliminated as a factor by irradiating rabbits with the head protected. Unless enormous doses were used, no cataract developed. On the other hand, a small dose to the eyes, with the rest of the body protected, did produce cataracts.

Since the direct effect of ionizing radiation on the lens was being intensively investigated in other centers, we at Northwestern University chose to investigate the second possibility, i.e., the effect of radiation on the ciliary body and the relationship of this to cataract formation.

The next few slides show the gross cataract produced in the rabbit by X-radiation. The total dose given varied from 2000 to 4000 roentgens. Doses as small as 500 r produced less marked opacities and the threshold seemed to lie at about 300 r.

The less marked changes caused by small doses are illustrated in the following slides taken from the work of Cogan[7], von Sallmann[8], and others. Of particular interest is this photograph taken from a paper by Alter and Leinfelder[9], which shows the opacity obtained by irradiating only a sector of the lens. Note that the opacities are limited to the area irradiated. The significance of this will be commented on shortly.

In our own laboratory, rabbits were sacrificed at varying intervals of time after irradiation, the eyes removed, and sections made to study the damage to the ciliary body. The results of this study were reported at length about a year ago[10]. From this paper the next three slides are taken which show that the ciliary body is injured by radiation to the eye and that this injury is transient in nature. Further studies on the permeability of the ciliary body to radioactive indicators[11] showed definite injury to the vascular system of the ciliary body but this too was transient in nature.

At the same time von Sallmann and his group at Columbia University[12] demonstrated beautifully that small doses of X-ray produce alterations in the mitosis of young lens fibers which are just beginning to differentiate at the equator of the lens. Apparently this interference with mitosis results in an altered lens fiber which becomes opaque on reaching the posterior cortex, and in this region the typical radiation cataract develops. It must be noted that in all probability, if the pupil were dilated widely enough, early changes could be seen in the region of the equator as they are in the rabbit.

At the moment, work is in progress which we hope will help elucidate the mechanism of injury to the young equatorial cells. In Strasbourg, France, Nordmann[13] and his group are investigating the carbohydrate enzymes in the irradiated lens, and our laboratory is investigating the enzymes known as the esterases. The difficulty lies in the fact that our histologic techniques are delicate enough to demonstrate injury to the nuclei of perhaps 10 or 20 cells, while no chemical method yet developed comes anywhere near this sensitivity. However, it is possible that the establishment of universal peace will make this whole problem academic. On the other hand, there is a greater probability that universal war will also eliminate the problem since, in order to have radiation cataracts, one must have survivors.

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# The Technic of Exchange Transfusion

**Robert S. Mendelsohn, M.D., Chicago**

EXCHANGE transfusion has become an established and important procedure in modern pediatrics. The technics of its performance vary widely from one hospital center to another and improvements frequently are added. At Sarah Morris Hospital, we have tried several different technics and have some appreciation of their relative merits and deficiencies. Our present method has developed from this experience.

The technic of exchange transfusion should be considered long before the birth of the baby. The finest method of transfusion may be ineffectual unless adequate advance preparations have been made. These should begin early in the prenatal period, when the physician, knowing the mother's blood type and previous medical and obstetric history, decides that she is likely to deliver an erythroblastotic infant. At this point he must select the place of delivery. Ideally, the child should be delivered in a hospital where there is a functioning, capable exchange team, so that in a matter of minutes, if necessary the procedure may be initiated if necessary. If this is not possible, then an ambulance should be waiting to transfer the child quickly to the exchange center. Considering the paramount importance of time as related to morbidity and mortality in these infants, there should be few instances in which babies are not delivered where all facilities are available. Whenever a child is transferred from another location, a sample of the mother's blood should accompany the child. Often we have found Rh determinations, Coomb's tests and in some instances even ABO typing unreliable in other smaller laboratories. We restudy the mother's blood in every instance.

Once the site of delivery is chosen, the next step occurs when the mother goes into labor. The obstetrician notifies the pediatrician of an impending erythroblastotic infant and the latter in turn alerts the team.

Let us consider for a moment the exchange team. In our hospital this consists of a staff pediatrician who personally supervises every transfusion, the chief resident who is on call for every transfusion, and three residents. The only permanent members of the team are the pediatrician and the chief resident [the latter, for one year]. The other positions are rotated among the house staff, changing every other month, for teaching reasons, and perpetuation of house staff participation. We feel that, with the two above-mentioned permanent members of the team, there is no disadvantage in rotating the other participants.

In addition to alerting the exchange team, the blood bank and operating room supervisors also are notified. Five hundred cc. of fresh whole blood is made available. Meanwhile the obstetrician has delivered the baby, leaving the umbilical cord a few inches long to facilitate later procedures. Cord blood is collected for determination of bilirubin, Hgb, typing and Coomb's test.

The pediatrician or pediatric resident examines the child immediately after delivery. If the child is severely erythroblastotic, he is transferred directly to the operating room. However, in most cases the baby is placed in the newborn nursery for observation. The nursing staff has two special duties in these cases. The first is to preserve the umbilical cord by keeping it moist with gauze dressings saturated with saline solution. The second is to observe the baby's skin color. The nurse will be more attentive if the physician conscientiously and deliberately integrates her into the team by explaining the importance of early detection of jaundice pallor, and other abnormalities.

After the decision to exchange the child has been made, the baby is moved to the operating room. All our exchange transfusions are carried out in the operating room to reduce the possibility of bacterial contamination and infection. A discussion of the problem of criteria for exchange transfusion is beyond the scope of this presentation except to mention that they are very much like those used in most institutions with special emphasis on bilirubin values; and whenever possible, the decision is reached after a joint conference of pediatrician, hematologist, and serologist.

The parents — in most instances only the father — should be thoroughly appraised of the serious nature of erythroblastosis and the necessity for the exchange. We believe the pediatrician can be reassuring while not minimizing the dangers inherent in this procedure.

The baby is placed in a Hess premature infant incubator with the cover removed. The stomach contents are aspirated with a syringe and gastric tube. Wooden blocks support the mattress so that it is almost level with the metallic edge of the bed. Preoperatively, vitamin K, penicillin, and streptomycin are injected intramuscularly. Oxygen is supplied via tubing and paper cone placed next to the baby's face. The baby is restrained on a Y board with towels. A stethoscope with diaphragm attachment is taped to the baby's chest, and the baby is then draped. Sterile sheets are also draped over the Hess bed. The umbilical cord and adjacent skin surfaces are cleansed with soap and water and 1:1000 aqueous Zephiran solution. An eye drape is then placed over the cord.

The team, scrubbed and gowned, is aligned in the following manner: One of the permanent members, either the staff pediatrician or the chief resident, who directs the procedure, sits at the head of the child and closely watches his condition. The umbilical cord is transected with a scalpel about ½ inch from the abdominal wall. It is then easy to identify the vein and the two arteries. The vein is canulated with a Bard venous catheter, usually size 7, but sometimes size 6. This is a rather firm woven nylon tube which can be autoclaved, while polyethylene tubes must be chemically sterilized. Because of the inadequacy of chemical sterilization, we prefer this type catheter. Thus, every instrument used in the exchange transfusion is sterilized by autoclaving.

Usually the cannula is easily inserted, but gentle pressure must be used in some instances, and in this particular action, previous experience in developing "a feel" for the channel is valuable. Once the pool is reached, as evidenced by the return of blood through the catheter, mosquito forceps may be placed around the catheter to mark and fix the site at which it is in the best position; then the rest of the setup, having been cleared of air and tested in advance, is attached. This consists of two three-way stopcocks in tandem, with one connected to the tubing from the bottle of blood and the other leading via rubber tubing to a basin for the withdrawn blood. One resident injects and withdraws the blood. A second cleanses the syringes, using a solution of isotonic NaCl, 1000 cc., to which 5,000 units of heparin have been added, and the third resident keeps tally of amounts in and out and other pertinent information.

In most cases 30-40 cc. of blood are initially withdrawn and following this, we inject and withdraw blood in 10 cc. units. Venous pressures are recorded at intervals by placing a spinal manometer in the system. This may be done by periodically disconnecting the syringe and attaching instead a manometer, or in difficult cases requiring close observation of the venous pressure, a third three-way stopcock with manometer attached may be connected. Venous pressure is maintained below 6 cm. of blood by varying the amounts withdrawn. Thus the danger of cardiac failure may be minimized. At the end of every 100 cc. injected, 2 cc. of 10% calcium gluconate are directly injected; this is done slowly with careful attention to the heart rate. We continue if the condition of the baby is satisfactory, until 500 cc. of blood are injected. This usually takes from 1 to 1½ hours.

After the transfusion is completed blood is withdrawn for bacteriologic culture. Vitamin K and antibiotics are again administered intramuscularly.

The baby is transferred to the children's hospital and kept in a Hess bed. The cord is kept moist. Feedings are withheld temporarily. Bilirubin determinations are performed as indicated, usually the first is done between six and 12 hours after transfusion.

When second and third transfusions must be done, we again attempt to cannulate the umbilical vein, usually with success on second exchanges if the cord was cut correctly and maintained in good condition. Often a clot must be removed from the vein by forceps.

Infrequently, on second exchanges but often on the third, the umbilical vessels are no longer patent and in these cases we cannulate the saphenous vein just before its entrance into the femoral, high on the thigh. The exchange transfusion then proceeds as described before. We have tried several other methods in the past, including using two cutdowns, one in the arm and one in the leg; a skin cutdown on the um-

bilical vessels; and a saphenous cutdown for injection and a nick in the radial artery for withdrawal. However, the described technic has been most successful in our hands.

Following the exchange transfusion, feedings are started after 12 hours; prophylactic antibiotics are continued for several days and the child usually is discharged from the hospital on about the 10th day of life. Small transfusions may be required for a few months thereafter. Since almost all these babies return to the care of private physicians on our staff, we have an excellent opportunity to follow their subsequent course, and such a study is now in progress.

Several technical difficulties can occur, including inability to pass the catheter, creation of a false passage along the umbilical vein wall, and clotting at the tip of the catheter or in the system. If the vein is correctly identified and excessive pressure is not used there is little likelihood of creating a false passage. Clotting in the system can be minimized by disconnecting the stopcocks periodically and flushing with heparin. Sometimes a clot at the end of the catheter prevents withdrawal of blood. In this event we insert another catheter. At any time the condition of the child may necessitate termination of the process; however, this is infrequent and in some cases may be due to too rapid transfer of blood resulting in cardiac dilatation and failure and pulmonary edema. Cardiac decompensation may occur following the exchange transfusion, and we have rapidly digitalized some babies with good results.

Although we know of instances in which pediatricians in isolated communities are doing exchange transfusions with the aid of another doctor of a nurse, we believe the team approach offers the opportunity for optimum conditions.

Of necessity, most of the procedural details are planned to be as routine as possible. However, the director of the team should make a conscientious effort to consider each step in a fresh light, no matter how often he has done them. Individualization is not only important to the child, but offers the best opportunities for continued improvement of the procedure for all children.

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## Make it more attractive

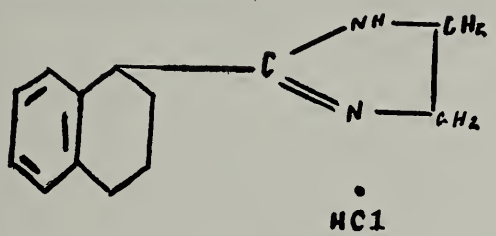
H. R. 9428 is a career incentive bill designed to attract and hold more doctors and dentists in the Uniformed Services. The bill would provide pay increases in the form of higher starting rank, longevity credit for the years spent in professional education, and a graduated series of increases in special pay. These increases will place Uniformed Service doctors more on a par, from a monetary standpoint, with their counterparts in Civil Service and Veterans Administration jobs. The Medical Career bill also will give doctors and dentists graduating from medical or dental school at least four years promotion list credit. Additional service credit will be granted to physicians for the required one-year internship, if served in a civilian hospital. *USAF News for Retired Personnel. April* 1956.

# Clinical Trial of Tyzine A New Nasal Decongestant

N. J. Katrana, M.D., East Moline

ALTHOUGH the clinician today has at his command a variety of effective nasal decongestants for routine use, their usefulness often has been limited by certain shortcomings. Thus the introduction of a new agent which, in preliminary trials, shows promise as a safe and potent vasoconstrictor is a welcome event to the practitioner who is called on to treat common upper respiratory ailments.

It is the purpose of this report to present the results of a clinical trial of a new compound, tetrahydrozoline hydrochloride (Tyzine®), as a nasal decongestant. Tyzine bears a chemical similarity to several other vasoconstrictors; it differs from naphazoline, to which it is most closely related, in bearing a saturated ring in its aromatic nucleus, and in having only one carbon atom between this ring and the nitrogen in the side chain. Its structural formula is:




Pharmacologic studies on animals reveal that it causes local but not systemic vasoconstriction when applied locally (intranasally) and that it is less toxic than naphazoline and phenylephrine when administered orally or parenterally.[1] Unlike some other decongestants, Tyzine applied in therapeutic concentrations does not inhibit tracheal ciliary activity in experimental animals.[2] This suggests that the normal method of mucus transport may be maintained while it is used to relieve nasal congestion.

Preliminary clinical reports[3-6] indicate that the superior results obtained in animal studies are confirmed in man. These studies agree in showing that Tyzine is equal or superior to other commonly used local vasoconstrictors.

## MATERIALS AND METHODS

This study presents evidence concerning the effectiveness of various concentrations of Tyzine in constricting nasal blood vessels. It was used in concentrations of 0.1 per cent, 0.075 per cent, and 0.05 per cent in treating 73 patients with common colds and allergic disorders accompanied by nasal congestion. The patients were an unselected series seen in office practice, and included both adults and children as young as four months.

Except in younger children, a standard dose of three or four drops of Tyzine solution was instilled into each nostril four times a day; thus the effect of the different concentrations could be compared directly. Only the more dilute solutions were employed in children under 5 years of age, and in some cases fewer drops of the solution were administered.

The results of treatment were rated excellent, fair, or poor according to its efficacy in clearing the nasal cavities. The effective duration of each dose and it ability to maintain vasoconstriction during the period of treatment were analyzed separately. The incidence and severity of undesirable side effects were noted, and care was taken in this series to watch for the occurrence of drowsiness due to the drug, since preliminary investigation[3] has shown that it occasionally exerts a sedative effect in infants.

## RESULTS

The results of treatment are presented in the table. Of 65 patients who were given Tyzine for upper respiratory infections, excellent results were obtained in 64 (98.5 per cent). The one patient who was only slightly benefited was a 50 year old man in whom the most dilute solution of the drug only incompletely cleared the congested nasal mucosa. However, even in this

Tyzine® (tetrahydrozoline) Nasal Solution was supplied for this study by the Medical Department, Pfizer Laboratories, Brooklyn, New York.

Results of Therapy with Tyzine in 73 Patients

| Strength of solution | Number of Cases | Excellent | Fair | Poor |
|---|---|---|---|---|
| 0.1% | | | | |
| Adults with common colds | 25 | 25 | | |
| 0.075% | | | | |
| Adults with common colds | 4 | 4 | | |
| Children with common colds | 20 | 20 | | |
| 0.05% | | | | |
| Adults with common colds | 7 | 6 | 1 | |
| Adults with allergic rhinitis | 6 | 4 | 2 | |
| Children with common colds | 9 | 9 | | |
| Children with allergic rhinitis | 2 | 2 | | |
| Total | 73 | 70 | 3 | |

case, the effect of Tyzine lasted for three to four hours with each dose.

The least concentrated solution (0.05 per cent) was used in treating 8 patients for allergic nasal congestion, with excellent results in 6 and some benefit in the other 2. Of the 2 children who used it, both obtained complete relief from congestion. One of these, a 9 year old girl who had ivy dermatitis involving a severe edema of the nasal mucosa, was benefited dramatically. Although she was being treated with cortisone at the time, it was clear that Tyzine was responsible for decongesting her nasal mucosa, since the effect followed its administration. The 0.05 per cent concentration was not as effective in adults in relieving congestion of allergic rhinitis. While all patients were benefited, and in 4 of the 6 patients congestion was completely cleared, the other 2 responded minimally; but again, the response lasted for several hours.

Inspection of the table would suggest that a solution of 0.05 per cent Tyzine represents the lower limit of concentration that is effective in adults, and is a satisfactory dose for children. Without exception, the 31 children 12 years old or younger responded excellently and were able to tolerate it without any noticeable side effects; drowsiness was not observed in any. The complete absence of undesirable reactions in children was more remarkable in that 8 were under 5 years of ago, 5 of them 3 years old or younger. One infant of four months benefited wonderfully. It should be noted that the youngest children were given only two drops in each nostril rather than the usual four.

The overall incidence of side effects was low, occurring in only 8 patients out of 73 adults. Five patients given the strongest solution (0.1 per cent) noticed slight palpitation; one patient experienced light nausea with palpitation. The other 2 patients who were highly nervous and irritable, noticed slight local irritation using the weakest solution (0.05 per cent). In no case were side effects sufficient to discontinue the drug.

A single dose was effective in maintaining vasoconstrictor action in a patient up to five hours. The average duration of effect was about three or four hours with the 0.1 per cent concentration, and somewhat less with the more dilute solutions. When administered to children, the more dilute solutions were usually effective for three or four hours. Tyzine was distinguished from other nasal decongestants in this series of patients by evoking no rebound congestion after its period of activity.

The prolonged effect of single doses was maintained throughout the course of treatment in most patients, even when Tyzine was given as long as a week. In only 8 patients, all adults, did the vasoconstrictor effect gradually diminish. Even in these cases the loss of effect was noticed only after four or five days; increasing the concentration often resulted in recovery of the vasoconstrictor action.

## SUMMARY

The results of this study demonstrate that a new nasal decongestant, Tyzine, has great activity as a local vasoconstrictor when applied to the nasal mucosa of patients suffering from infectious and allergic disorders in which the mucosa is inflamed. Its side effects were negligible in adults and completely lacking in children, even in infants as young as four months. Its beneficial effects were judged excellent in 96 per cent of the 73 patients studied. The effect of a single dose was maintained up to five hours and was never followed by rebound congestion. Only rarely did Tyzine fail to maintain its effectiveness throughout the duration of treatment; even in these instances, effectiveness was often restored by increasing the concentration. In no case was it completely without effect.

The use of the drug was facilitated by the fact that almost all the patients found it tasteless, odorless, and without irritation. In the

judgment of the investigator, Tyzine produced clinical results superior to those obtained with other nasal decongestants.

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## Mended Hearts, Inc.

A few years ago, under the encouraging name of Mended Hearts, Inc., a small group of patients in Boston who had recovered from and benefited by heart surgery formed such an association. They were inspired by the fact of having been lifted out of a dead-end street and set once more on the highway of life. They wanted to share this feeling of spiritual as well as physical renascence and adopted as their cheerful if not utterly original slogan, "It's great to be alive — and to help others." The organization includes not only veterans of heart surgery who are rehabilitated or are being rehabilitated but also, as associate members, their interested relatives and friends. There is an enthusiasm about emerging from the valley of the shadow, and the last annual meeting in June of 1955 brought forth an attendance of 750, of whom 400 were veterans of cardiac surgery, ranging in age from 9 to 64. A function of active members of the society is to visit patients anticipating or recovering from surgery of the heart (with the approval of their physicians); to lend encouragement as living examples of what can be accomplished; to hand on, as the doctor can hardly do, an appraisal of the emotional stress through which patients must so often pass alone. The society advises and helps on matters relative to diet and food products and in many ways serves in an ancillary capacity to the surgeon and cardiologist. *Editorial. Mended Hearts. New England J. Med. March* 29, 1956.

## Curiosity killed the cat

Well publicized curiosity once killed a proverbial cat — and it can drive a human to distraction, once given the chance. Case in point: The married man who, plagued by his wife's repeated visits to her mother, sent her copies of the local paper with items carefully clipped from the pages. Curiosity — and suspicion that the deleted news items said things her husband did not want her to see — brought her home promptly. That is the devastating power or curiosity. *Grit and Grist. Wastes Engineering. March* 1956.

# CASE REPORTS



# Traumatic Diaphragmatic Hernia Due to Stab Wound of the Chest

**Joseph A. Griffin, M.D.*; Albert J. Pisani, M.D.*; Philip Sheridan, M.D.* and Arthur Bernstein, M.D.†, Chicago**

DIAPHRAGMATIC hernia has received considerable attention since the advent of roentgenography. But the condition has been known for a long time. Ambroise Pare[1] described two cases in 1575, both of traumatic origin and one involved the stomach; the other, the colon. Hildanaus[2] in 1608, reported a case. The patient recovered from the sword wound of the chest but three months later developed chills, fever, and "black vomiting". Autopsy findings showed the entire stomach herniated into the chest.

A 25 year old colored male entered Cook County Hospital on February 28, 1955, with intermittent abdominal cramps of three days' duration. He had indulged heavily in alcohol just prior to the appearance of cramps which he described as diffuse gas pains. The attacks occurred at intervals during the day and lasted 2-3 minutes, followed by complete relief. Frequency of pain seemed to be lessened by sitting. Anorexia, nausea, and constipation were prominent but flatus was passed. Twenty-four hours prior to admission abdominal cramping became more severe and the patient vomited all food and water immediately after ingestion.

Past history revealed that the patient had been hospitalized elsewhere in 1948, for one month, due to a knife wound of the left. He was treated conservatively; no surgical exploration was done.

Physical findings on admission were few. Blood pressure 130/90; pulse 110; respiration 20/minute; temperature 98.8. The oral mucosa showed fair hydration. Chest examination revealed dullness in the left base posteriorly, with limitation of excursion of the left diaphragm, and breath sounds over this area were diminished. The abdomen was scaphoid in appearance, soft, and nontender. There were no palpable masses or viscera. Bowel sounds were active and of normal intensity. The rectum was normal; fecal matter was present and tested negative for occult blood.

Laboratory findings were: Urine, negative; hemoglobin, 102 per cent ; W. B. C. 6,250; differential 54 polymorphs, 5 bands, 26 lymphocytes, and 13 monocytes. Serology was negative. Blood chemistries revealed N.P.N. 66 mg. per cent; creatinine 1.6 mg. per cent; sodium 136 mEq./L.; chloride 93 mEq./L.; potassium 4.2

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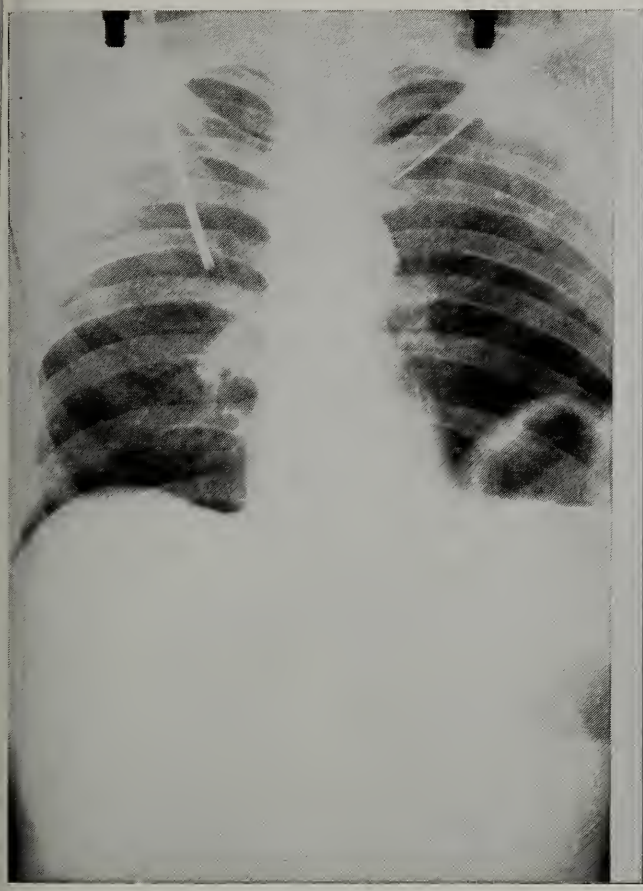


Figure 1

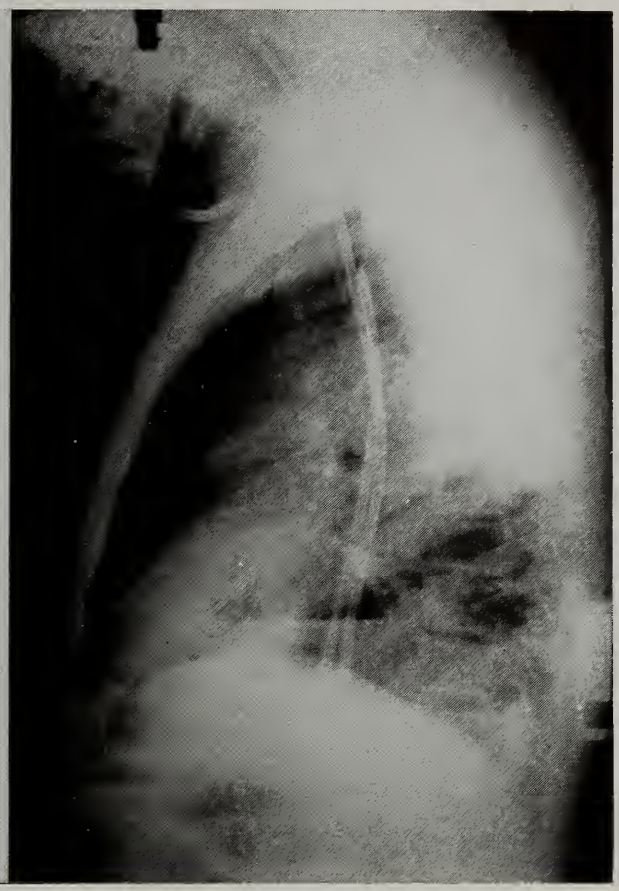


Figure 2

mEq./L.; $CO_2$ combining power 59 Vol. per cent.

Admission chest film showed slight blunting of the left costophrenic sinus with minimal elevation of the left diaphragm.

Alcoholic gastritis was the diagnosis and the patient was treated conservatively. Parenteral fluids, antibiotics, and a liquid diet were prescribed. He appeared to do well for 36 hours. However, 36 hours after admission severe colicky abdominal pain and vomiting again developed. Abdominal findings at this time revealed a uniform distention with minimal tenderness on deep palpation, and rebound tenderness in the periumbilical region. Bowel sounds were hypoactive with occasional short rushes of high pitched sounds. At this time re-examination of the chest revealed two scars of the old stab wounds measuring 2 cm. in length; one in the 4th interspace in the anterior axillary line; the other, in the 6th interspace in the midaxillary line.

Repeat chest film at this time revealed elevation of the left diaphragm, with bowel shadows in the left hemithorax (Figure 1). A lateral view of the chest showed a gas bubble with fluid level in the anterior portion of the left chest (Figure 2). Left lateral decubitus and upright view of the abdomen demonstrated the stepladder design of the small bowel indicative of mechanical obstruction (Figures 3 and 4). The barium enema penetrated only to the splenic flexure where it ended abruptly in a conical fashion (Figure 5). Accordingly, a diagnosis was made of mechanical intestinal obstruction due to incarcerated diaphragmatic hernia.

Celiotomy was performed on March 3, 1955, through an upper left paramedian incision. Upon entering the peritoneal cavity it was seen that the

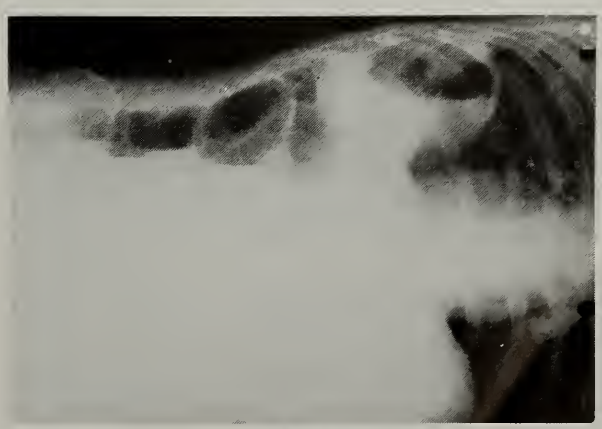


Figure 3



Figure 4



Figure 5

colon was markedly distended up to the region of the splenic flexure. The small intestine distal to the midjejunum also was somewhat distended. Further inspection showed herniation of the splenic flexure of the colon, as well as a large segment of omentum, through a five cm. defect in the dome of the left hemidiaphragm. Distal to this point the colon was collapsed.

Division of adhesions between the bowel wall and the hernial ring made it possible to reduce the herniated colon by traction. Viability of the colon was intact. There was a moderate amount of adhesions in the region of the diaphragmatic defect, but no sac was present. Closure of the diaphragm was effected with interrupted silk mattress sutures. At the end of the procedure active peristaltic waves were seen to pass through the segment of bowel that had been incarcerated. The abdomen was closed in layers and a water seal drainage tube was placed in the lower left hemithorax.

Postoperatively the patient developed a left basilar atelectasis which responded to antibiotics and active cough stimulation. The course was otherwise uneventful, and he was discharged on the 30th postoperative day.

## DISCUSSION

The classification of traumatic hernia by Harrington (4,5,6,7) divides traumatic diaphragmatic hernias into those caused by direct or indirect injury and inflammatory necrosis of the diaphragm. In a series of 524 cases of diaphragmatic hernia operated on by Harrington[4] 60 were due to various types of trauma. Six of these were due to direct injury to the diaphragm; five of which were secondary to gunshot wounds and only one was due to a stab wound. The remaining 54 hernias were due to indirect trauma to the diaphragm of which 42 were secondary to automobile accidents. The remaining 12 were due to various causes such as falls from ladders or horses. Seven cases of the 524 were due to inflammatory necrosis resulting from subphrenic abscess or drainage of empyema.

Review of the recent literature reveals stab wounds as infrequent causes of diaphragmatic hernia. However, it has been pointed out that actual herniation may occur months or years after the initial injury[8]. Gibson[9] reports one case of intestinal obstruction occurring three years after a stab wound of the left lower thorax. In

our case, intestinal obstruction oeeurred seven years after the stab wound to the chest.

Traumatic diaphragmatic hernia usually is on the left side. A similar wound of the right dome of the diaphragm is plugged by the compact and plastic liver, preventing herniation. Every case of left sided stab wound of the ehest may be a potential diaphragmatic hernia.

In a wound of the left diaphragm, the force of aspiration of the thorax is exerted upon the freely movable abdominal viscera. The constant suction aetion of the thorax, due to its negative pressure, may result in the entrance of the omentum into the opening, where it adheres and prevents closure of the edges of the opening. The normal movement of the diaphragm also prevents this union. Adhesions form between adjacent abdominal viscera and thoraeic viscera. Contraction of these adhesions results in organs of the abdomen being pulled upward into the chest. The stomach is the most eommon organ to herniate and, aceording to Giffin[10] a portion of the colon usually accompanies it. Less often the small intestine, spleen, liver, panereas, and kidney are found in the thorax.

The symptoms of diaphragmatic hernia depend upon the various structures involved in the hernia. The function of the herniated abdominal viscera is interfered with meehanically. The increased pressure within the thorax may eause impairment of respiration and circulation[4]. The symptomatology is varied, ranging from mild digestive disturbances to marked interference with heart aetion and respiration. The most eommon symptom is epigastric pain or substernal discomfort. Severe hemorrhage[11,12,13,14] from the gastrointestinal tract may occur as a result of inearceration or strangulation of hollow viscera as well as ulceration of the stomach. Obstruetion of the inearcerated bowel also oceurs, as it did in our ease.

X-ray is the most important aid to diagnosis. Chest film, barium meal, and barium enema aid in determining the contents, size, and location of the hernia[4].

The chest film should be the first step in the roentgen investigation.[8] It may show a tenting of the diaphragm or obliteration of the costophrenic sinus, such as is seen in an old pleuritis, pneumonitis, or pulmonary neoplasm. Large diaphragmatic hernias, especially when a large segment of bowel or stomach is fixed or incarcerated in the thoracic cavity, are dramatically visualized by X-ray examination of the chest.

Herniation of the colon cannot be excluded except by barium enema. If the small bowel only is involved, examination with an opaque meal is necessary before the diagnosis can be made.

Among the important differential diagnostic considerations in diaphragmatic hernia are angina peetoris, gall bladder disease, and peptic ulcer.

## SUMMARY

We are herewith reporting a case of traumatic diaphragmatic hernia caused by stab wounds of the left chest, complicated by intestinal obstruction. The onset of acute vomiting due to alcoholic excess apparently was the cause of the incarceration and obstruction of the bowel in the diaphragmatic defect.

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# Delayed Visualization Of The Gall Bladder Due To Gastric Retention

S. A. Leader, M.D., Chicago

IT is well known that delayed visualization of the gall bladder and even nonvisualization may occur occasionally after oral administration of iodine compounds without any organic disease of the gall bladder or the biliary tract. This case illustrates one reason for this occurrence.

G.N. Patient, a white male, aged 35, was admitted September 8, 1954, with a history of numerous hospitalizations since 1947, for "polyneuritis." This began in the feet in 1943, later involved the legs, and then fingers and hands. The condition was variously diagnosed as cauda equina tumor, polyneuritis, syringomyelia, and Charcot-Marie-Tooth type of neuropathic muscular atrophy. In addition he had had attacks of diarrhea since 1947.

High vitamin therapy was given and in 1954 he received without benefit X-ray therapy-1200 r to cervical, thoracic, and lumbar spine.

Two points were significant in his family history: His father had suffered from weakness of arms and legs and bladder and bowel difficulty, and could not get around; there was a question of an uncle having a similar condition.

Physical examination on admission revealed an emaciated white male with a trophic ulcer over the left ischium. The neurologic findings were: Severe atrophy of all the extremities, loss of motor power below the knees, weakness of the hands, loss of deep and superficial reflexes of the lower extremities and forearms, loss of all sensation below knees and elbows and of body anteriorly to D-2, and paresis of the rectum and bladder.

Laboratory findings: RBC 2,940,000, hemoglobin 9 gm., hematocrit 25%, WBC 11,400. Differential: 64% neutrophils, 23% lymphocytes, 8% bands, 2% eosinophils, 3% monocytes. A/G ratio 3.5/2.9. Cultures and smears of the stools were negative on 12-27-54. Bone study showed a nonspecific pattern. On 5-10-55, biopsy of the peroneal nerve revealed periarteritis. On 7-11-55, muscle biopsy demonstrated only atrophy.

In January 1955, he developed hemologous serum jaundice following transfusion for anemia.

X-ray examination: At 10:00 P.M. on 6-2-55 he was given 3.0 gm. of Telepaque® (3- (3-amino - 2, 4, 6, - triidophenyl 1) -2 - ethyl propionic acid). At 8:30 a.m. on 6-3-55, a film revealed a large amount of contrast material in the stomach but none in the gall bladder (Figure 1). After a fatty meal, the material disappeared almost completely from the stomach and only a few flecks were seen in the colon (Figure 2). At 3:30 p.m. on 6-3-55, the gall bladder shadow was faintly outlined and the following morning, the organ was well visualized and appeared normal (Figure 3). Gastrointestinal study on 6-8-55 revealed only gastric retention. (On 10-22-54 gastrointestinal examination had demonstrated some gastric retention and disordered small bowel pattern.)

## DISCUSSION

It is obvious that in this case delayed visualization was due to failure of the Telepaque to reach the small bowel where absorption takes place. Feldman[2] states that pyloroduodenal obstruction usually is incomplete and has little or no effect on cholecystography; he cites 21 cases of pyloric obstruction with gastric retention for four to 24 hours; the gall bladder filled normally in 15, faintly in 6, and not at all in 3.

Gottlieb and Beranbaum[3] reported 7 cases with a gastric residue during cholecystography with Priodax®. Five were found to have organic lesions of the stomach, duodenum, or gall bladder. In three, the gall bladder was not visualized but no gastrointestinal disease was found at surgery. These authors emphasize the fact that nonvisualization of the gall bladder is not syn-

*Clinical Assistant Professor of Radiology, University of Illinois, College of Medicine*

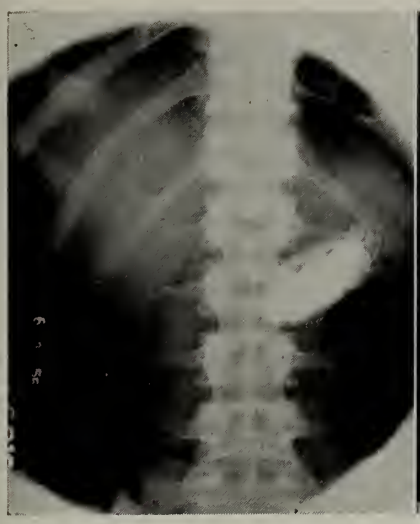


Figure 1



Figure 2

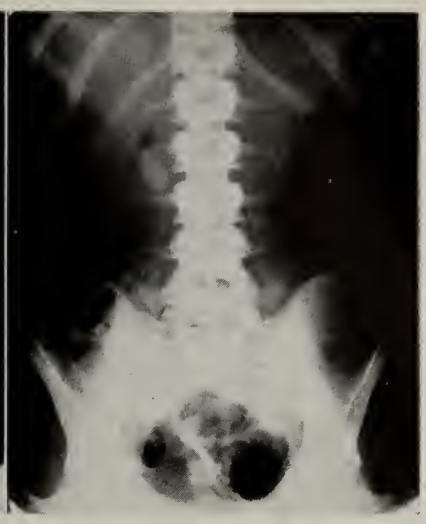


Figure 3

onymous with a pathologie gall bladder, espeeially with delayed gastric evaeuation of the gall bladder dye. Since reading Gottlieb and Beranbaum's artiele reeently, a ease was seen with a small residue in the duodenal bulb after choleeystography and gastrointestinal series revealed a duodenal ulcer.

Tepliet and Adelman[4] reeently reported 5 eases with gastric retention during cholecystography; one of these also had a small residue in the lower esophagus and subsequent barium studies diselosed aehalasia. Another had retained opaque material below the gall bladder (as well as in the stomaeh) and was found to have a duodenal diverticulum as well as duodenal ulcer. The other three had gastric or duodenal ulcer. They mention 2 other cases with gastric residue in whom no disease of the stomaeh or duodenum was demonstrated. They emphasize (as did Gottlieb and Beranbaum) that gastric retention in choleeystography is more significant than a six hour barium residue. They advise careful serutiny of cholecystograms (using Telepaque) for gastric retention and point out that this could be overlooked or mistaken for opaque material in the colon.

## SUMMARY


1. A ease of delayed visualization of the gall bladder due to gastric retention is reported.
2. The fact that delayed visualization or nonvisualization of the gall bladder does not necessarily signify gall bladder disease is emphasized.
3. The importance of searehing for gastric residues after cholecystography is noted.


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# Rupture of Papillary Heart Muscle Following Myocardial Infarction With Present Survival of Over Three Years

G. J. Kidera, M.D., C. E. Murphy, M.D., and J. N. Waggoner, M.D., Chicago

COMPLICATIONS of myocardial infarction are variable. Arrhythmias occur so frequently they can almost be considered an associated sign. Ventricular rupture, aneurysm, and embolic phenomenon from thrombi are encountered relatively infrequently. Extremely rare is rupture of a papillary muscle or perforation of an interventricular septum.

In 1934, Sager,[1] in a review of the literature, found 18 cases of perforated septum. By 1948 Fowler and Failey,[2] reported a total of 58 cases. In a 1952 report[3] the number had increased to 75 in which diagnosis was made antemortem in 28. It is apparent that, while the incidence of this acquired septal defect is low, its recognition rate during life is also low. Geckeler et al[4] reported a case with early perforation of the septum; diagnosis was made 12 hours after symptoms appeared. Their review of the literature of myocardial infarction showed the average time of perforation to be slightly over seven days after onset. Survival time in more than 50% thereafter was less than a week. Wood and Livezey[5] reported an unusual case with survival for five years, while Zucker[3] et al reported one with four and a half year survival.

Rupture of a papillary muscle of the heart is even rarer than perforation of the interventricular septum. In 1948 Davison[6] found 29 cases of ruptured papillary muscle; in 1953 Craddock and Mahe[7] reported, with their three cases, a total of only 43 cases of ruptured papillary muscle. Of these, 34 were due to previous myocardial infarction, two to trauma, two to ulcerative endocarditis, two to periarteritis nodosa, one to syphilis, and two of unknown etiology.

In case of myocardial infarction when murmur develops, its location is important in the differential diagnosis of a ruptured papillary muscle or perforation of the septum. In over 90% of cases of the latter, murmur is heard which is loudest at the 3rd to the 5th interspace, just to the left of the sternum, and usually systolic. The murmur is loud. A thrill is present in over half the cases and an electrocardiogram may show advanced conduction disturbances. With muscle rupture there is a very loud, often whistling, usually systolic murmur, heard with maximum intensity over the apex, and transmitted over the precordium. There has never been a thrill recorded, and the cardiogram may show exaggeration of the original pattern of myocardial infarction but no unusual conduction defects.[7] Rupture of the chordae tendineae can cause a harsh systolic murmur and thrill, but has been reported only in long standing heart disease, and in no instance following infarction. Bacterial endocarditis usually precedes this.

The following is a report of a case of a presumed ruptured papillary muscle of the heart. An airline captain had been seen annually for many years at the company medical department for complete physical examination. In 1947 his electrocardiogram had shown a slightly prolonged PR interval, but on recheck a few days later this was within normal limits. Subsequent annual examinations to 1952 had never shown abnormal physical or laboratory findings. Both his father, at age 65, and a brother, at age 41, had died of coronary artery disease, and his mother died following a stroke.

At age 45, early in September 1952, while eating, he developed substernal pain radiating to neck and shoulders. Pain was dull and burning and subsided spontaneously, but recurred

that evening and again subsided. He was seen by a physician the next day. Physical examination then was normal but electrocardiogram showed a high peaked T in $V_2$ and peaked T in $V_3$ and $V_4$, suggesting some degree of ischemia. On September 13, 1952 the cardiogram showed progressive changes suggesting infarction. A ballistocardiogram, Dock modification, on normal breathing, exhibited slight irregularity of pattern with varying depth of K waves. On held inspiration the pattern became regular and definite, while on held expiration the pattern was slightly irregular with occasionally notched J wave. It was considered as Brown Grade I, and not a grossly abnormal tracing. Two weeks later the unipolar leads in the electrocardiogram showed an elevated ST segment and high peaked T waves in $V_2$ and $V_3$, and inverted coved T in $V_5$ and $V_6$.

On October 8, 1952, he was seen at the Chicago Medical Department of the air line. Pertinent findings then were pulse 105, BP 130/80, sedimentation rate of 22 mm., and an abnormal flicker fusion reaction after nitroglycerin. There was a very rough loud systolic murmur heard over the entire precordium, but with maximum intensity at the apex. This murmur was not present on any previous examination. There was cardiac enlargement on X-ray. No aneurysmal bulging of the left ventricle was seen. The electrocardiogram did not show inversion of the T wave in $V_5$ and $V_6$, as noted above but the high peaked T was still present in leads from the right side of the precordium.

Early in December he was referred to a cardiologist for opinion. It was his belief, as a result of the infarction, a small break through in the interventricular septum had occurred, or a rupture of one of the mitral papillary muscles. Supporting the latter possibility was some enlargement of the left ventricle on fluoroscopy.

In September 1953 he was referred to another cardiologist, who also found the loud systolic murmur heard best at the apex, but also well transmitted to axilla and base. The electrocardiogram was considered rather typical of a healed posterior wall infarct with lateral wall extension. In contradistinction to the ballistrocardiogram of a year earlier, a tracing was thought rather typical of coronary disease with deep HI segments, low IJ amplitude, and high amplitude I, waves. The accleration curves showed notched components indicating evidence of poor ability to acclerate blood and evidencing that the velocity of filling was increased, with a decreased velocity of ejection. The murmur, it was thought, "probably represents changes due to a ruptured papillary muscle but this is uncertain."

This patient has been off active flight status as a pilot since the original episode in September 1952. He was returned to work in early January 1953, in an administrative ground position. He has done a good deal of flying since, as a passenger; in early October 1952, about five weeks after his original chest discomfort, he made his first flight. Subjective complaints at all times have been meager — there is no dyspnea on ordinary activity. He has noticed that on visits to Denver, with its mile high altitude, he has a moderate tachycardia with the pulse running some few beats over 100. His adjustment to the cardiac accident and subsequent removal from flight status to an entirely different regimen of life, has been adult and excellent. His activities are not particularly restricted, other than the avoidance of undue effort. Our most recent electrocardiogram in September 1955 showed normal PR and QRS intervals, inverted T wave in leads III, AVR and $V_6$ and a Q wave in III and AVF.

Prognosis is uncertain as to length of life in either a perforation of the interventricular septum, or a ruptured papillary muscle following infarction. Askey[8] had a patient survive six months after papillary muscle rupture, but states that this injury is usually more catastrophic with sudden collapse and death in a few hours. Wood and Livezey,[5] of 36 cases collected prior to their report of one who survived almost five years after interventricular septal perforation, say that of the others, only seven lived longer than a month, and none as long as a year.

## SUMMARY

A case is presented of presumed rupture of the papillary muscle of the heart following myocardial infarction in an air line captain. Methods of distinguishing between this complication and perforated interventricular septum are noted. While rupture of a papillary muscle is uncommon in itself, this case is the more so

because of survival time, at present, of over three years with relatively no trouble.

Medical Department, United Air Lines, Chicago.

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## Social trends

The attitudes of many younger physicians toward social security, group practice, etc., represent opinions evolving to meet changing circumstances. These we must respect though many may disagree with them, but the basic law of the Ten Commandments still governs all. We must not confuse professional ethical principles with elemental moral truths, though both are apt to be in agreement. Expediency solves only the problems of the moment. It may not chart a safe course for the future. We must not be, as Oliver Goldsmith so ably wrote: "Too fond of the right to pursue the expedient." *Harold B. Harris, M.D. Our Changing Times. Massachusetts Physician. May* 1956.

## We are interested

Some groups and individuals are obviously possessed by the strange philosophy that only the "blue collar" class is interested in the common welfare, that humanitarianism is a quality reserved to certain political parties, and that public service is a personal thing incapable of accomplishment by the group, particularly a medical group. It is as if the physician is a Doctor Jekyll-Mr. Hyde, kind and gentle to his patients but conniving and treacherous when conferring with his colleagues. *Editorial, Polls and Public Opinion. J. Indiana M. A. May* 1956.

# EDITORIALS




## The 1956 annual meeting

The 1956 annual meeting of the Illinois State Medical Society was held in the Hotel Sherman, Chicago, May 15-18. The meeting was well attended and the scientific programs were believed to be the best that have ever been scheduled by the Society.

The meetings of the House of Delegates were well attended and much business was transacted during the three sessions of the House. All technical exhibit booths were filled and the scientific exhibit was larger than usual, with a fine array of exhibits arranged by Dr. Coye Mason, Director of Scientific Exhibits. It was quite a problem for the secret committee on awards to make their selections for the several awards given each year to scientific exhibitors.

The Society was fortunate in having Dr. Elmer Hess, president of the A.M.A. present throughout the entire session. Dr. Hess appeared before the House of Delegates, the Woman's Auxiliary, meetings of the Council and made the address at the Annual dinner on Wednesday evening.

The awards presented to scientific exhibitors, were given in two classifications; for educational value and for original work. The recipients of the awards are as follows;

EDUCATIONAL VALUE

GOLD MEDAL — Booth 4

Title: "Surgical Complications of Pregnancy"

Exhibitor: Frederick H. Falls and Miss Charlotte S. Holt

Institution: University of Illinois College of Medicine

SILVER MEDAL — Booth 14

Title: "Better Medical Writing"

Exhibitor: Lee D. VanAntwerp, Harold Swanberg

Institution: American Medical Writers' Association

BRONZE MEDALS

1. Booth 21

Title: "The Doctor, the Vocational Rehabilitation Team, and the Vocational Rehabilitation Client"

Exhibitor: E. C. Cline

Institution: Illinois Division of Vocational Rehabilitation

2. Booth 1

Title: "Surgical Treatment of Varicose Veins by Two-Team Technique"

Exhibitor: Arkell M. Vaughn, Cornelius M. Annan and John A. Caserta

Institution: Department of Surgery, Stritch School of Medicine, Loyola University, Mercy Hospital, and the Vaughn Medical Group

3. Booth 3

Title: "A Better Understanding of Acid-Base Balance"

Exhibitor: Harry F. Weisberg

Institution: Mt. Sinai Medical Research Foundation and the Chicago Medical School

ORIGINAL WORK

GOLD MEDAL — Booth 10

Title: "Potentially Pathogenic Bacteria Carried in the Respiratory Tracts of Physicians"

Exhibitor: Jerome J. Landy, Isabelle Havens, Ross S. Benham

Institution: University of Oklahoma, University of Chicago

SILVER MEDAL — Booth 24
Title: "A New Method of Pelvic Fixation"
Exhibitor: William Johnson
Institution: The Galesburg Clinic

BRONZE MEDALS
1. Booth 11
Title: "Controlled Arrest for Cardiac Surgery with Hypothermia"
Exhibitor: Peter V. Moulder, Richard G. Thompson, Robert Harrison, William Kiskind, Barry Siegal, Curtis A. Smith, and William E. Adams
Institution: University of Chicago, Department of Surgery
2. Booth 2
Title: "Alterations in the Central Nervous System Associated with Various Fungous Infections"
Exhibitor: Louis D. Boshes
Institution: Division of Neurology and Psychiatry, Department of Medicine and Microbiology, Michael Reese Hospital. Department of Neurology and Psychiatry, Northwestern University Medical School
3. Booth 16
Title: Palliation of Esophageal Obstruction Due to Carcinoma With A Permanent Intraluminal Tube"
Exhibitor: S. A. Mackler, G. Bard
Institution: Cook County Hospital, Department of Thoracic Surgery, Michael Reese Hospital, Chicago Medical School.

At the last session of the House of Delegates on Friday morning, F. Lee Stone was inducted into the office of president by the retiring president, F. Garm Norbury.

The following officers and members of the Council were elected at this last session of the House: President-Elect Lester S. Reavley, Sterling; 1st Vice President, Frank H. Fowler, Chicago; 2nd Vice President, Norman L. Sheehe, Rockford; Secretary-Treasurer, Harold M. Camp, Monmouth.

Members of the Council; elected for three year terms: 1st District—Carl E. Clark, Sycamore; 2nd District—Joseph T. O'Neill, Ottawa; 3rd District—E. A. Piszczek, Chicago; Caesar Portes, Chicago; 11th District—Edwin S. Hamilton, Kankakee.

F. Garm Norbury, the retiring president, automatically became a Councilor at large for one year, and H. Close Hesseltine, Chicago, became the Chairman of the Council for the fiscal year.

Delegates to the American Medical Association: two year terms. Percy E. Hopkins, Chicago. Chas. H. Phifer, Chicago. Warren W. Furey, Chicago. C. Paul White, Kewanee. Burtis E. Montgomery, Harrisburg.

Alternate Delegates to the A. M. A.: two year terms. Maurice M. Hoeltgen, Chicago. Leo P. A. Sweeney, Chicago. Carl F. Steinhoff, Chicago. Harry Mantz, Alton. Joseph T. O'Neill, Ottawa.

The House of Delegates unanimously approved the recommendation that the annual dues remain the same for 1957, as for the past year, $40.00 plus $25.00 A.M.A. dues.

The 1957 annual meeting will be held at the Hotel Sherman May 22-25. At the closing session of the House of Delegates, all those responsible for making this 1956 annual meeting a highly successful one, were given a rising vote of thanks.

## Increasing the cost of medical care

Britain's drug bill is exorbitant because everything from estrogens to aspirin is "free." Socialized medicine is practiced also in Australia and in New Zealand but the cost is kept low because they are less generous. In New Zealand, for example, a more expensive drug is obtained free on prescription, provided it is filled through hospitals and only when the illness failed to respond to a less expensive product.

In Australia, drugs that are lifesaving or disease preventing are free. The public is able to obtain erythromycin for pneumonia but they pay for their own bromides, tranquilizers and cough medicines.

The members of the British National Health Service are aware of these schemes but do not intend to change. There are no strings attached to their system. No questions are asked, for example, when a physician orders cortisone for his arthritic patients. The same can be said for sedatives, vitamins, and Epsom salts. There are



F. Lee Stone, M.D.
President, Illinois State Medical Society
1956 — 1957

no restrictions, limitations, or committees to pass on what he orders.

The English believe that the few colleagues who exploit the system do less harm than a therapeutic dictatorship. They are against political controls that influence judgment and undermine the initiative and sense of responsibility of the individual practitioners.

This philosophy is sound. It is conceivable that by giving the physician more responsibility he will respond by using better judgment in prescribing. In this respect each medico becomes his own censor.

## Polio vaccine regulations in Illinois*

All persons under 20 years and over 6 months of age are now eligible for polio vaccine. All pregnant women are eligible. Vaccine for a third or "booster" dose for all persons vaccinated prior to December, 1955 is also available.

This announcement has been made by Dr. Roland R. Cross, State health director, who said that the eligibility age has been broadened and "booster" doses authorized because polio vaccine is now more plentiful than heretofore. Only persons between 1 and 15 years of age and pregnant women had been eligible for polio vaccine until now.

An official letter announcing that persons up to 20 years of age are now eligible for polio vaccine and that booster doses are authorized was mailed to all physicians in Illinois.

Polio vaccine is available to physicians from any full-time local health department. Doctors in areas where there are no full-time local health departments may obtain vaccine direct from the State Department of Public Health at Springfield.

"With the main polio season in Illinois only a few weeks away, every eligible person should take advantage of vaccination promptly," Dr. Cross said. "Experience indicates that the preventive protection given by vaccine is substantial," he added.

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*Released June 11, 1956 by the Illinois Department of Public Health, Roland R. Cross, M.D., Director.

## Collection and submission of specimens for poliomyelitis diagnosis

For a reliable laboratory diagnosis of poliomyelitis or aseptic meningitis caused by other viruses such as the coxsackie group, it is important that a stool specimen and paired (acute and convalescent) blood or serum specimens be submitted. These specimens should be collected as indicated below.

A stool specimen and acute blood should be collected as early as possible after onset (preferably within 1 week). The stool specimen should be collected in a dry, sterile bottle, and sent to the Chicago laboratory as promptly as possible, but may be held under refrigeration overnight before mailing. In very hot weather when shipment will require longer than 24 hours, dry ice or "canned ice" should be used in an insulated carton shipped via express. The acute blood specimen may be mailed directly but it is preferred, whenever possible, that the hospital laboratory separate the serum (3 to 5 cc.) and hold in a sterile stoppered tube in the refrigerator until the convalescent sera can be obtained, 3 to 4 weeks after onset. The paired sera properly identified as to date of collection should be submitted together. All specimens should be accompanied by a completed PHS 400 form. These forms and appropriate containers are available on request from the nearest branch laboratory of the Illinois Department of Public Health.

### Interpretation of Poliomyelitis Laboratory Tests

1. Culture of the stool will usually reveal polio virus in approximately 90% of paralytic cases but in only about 40% of nonparalytic cases. Serological tests will detect evidence of infection with polio virus in a high percentage of all cases if specimens are collected at the proper time. Stool cultures, however, will often reveal the presence of viruses other than polio that cannot easily be detected by serological methods. In such instances it is necessary to demonstrate a rising antibody titer in the patient's sera to establish the role of the virus in the patient's illness.

2. Antibodies against the infecting virus appear in response to infection, regardless of whether the infection is accompanied by illness or, as in most cases, is inapparent. Prior to age

6 months antibodies transmitted from the mother may be detectable. Recent inoculations of polio vaccine may produce a rising antibody titer.

3. Two kinds of antibodies are known; neutralizing and complement-fixing. The former appear earlier and are long lasting, perhaps for life, whereas the latter are short-lived and within several months after infection, may be absent or at low levels. In rare instances complement fixing antibodies wil be present in the absence of neutralizing antibodies. Also in rare instances complement fixing antibodies may be delayed in appearance as much as several months after infection.

4. Serologic *tests on a single serum specimen are of no value in diagnosis,* since normal individuals may have antibodies from previous infection. In order to demonstrate that antibodies in the patient's serum resulted from the illness in question, serum collected as early as possible after onset (within 1 week) and again 3-4 weeks after onset, must be tested. At least a four-fold rise in titer between the first and second specimen must be demonstrated to be of diagnostic value. A declining titer may also suggest a recent infection. Serological tests will be reported for each of the three known types of polio virus. However, because of cross reactions between these antigens, the infecting type will not always be discernible.

*Illinois Department of Public Health*

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## Inaugural remarks by F. Lee Stone, M.D.

There are many honors that can befall a man, but none so great as when his colleagues place him at the head of their organization. I am humbly mindful of the privilege and of the serious obligations which the presidency of the Illinois State Medical Society imposes.

During the past year, "Garm" Norbury's inspirational leadership has made my indoctrination as president-elect pleasant and memorable. Much of what I shall do during the coming year will be in support of the ideas which he has sponsored, with the hope that perhaps I, too, may contribute something to the aims of our profession in general and the aspirations of the Illinois State Medical Society in particular.

Our state legislature will assemble for its regular biennial session during the year ahead. As in the past, there will be a number of measures with medical implications presented before this body. We will have to be alert to those which threaten the quality of medical care that is being provided for our citizens, and strong in support of those that will make the practice of medicine in Illinois second to none.

Despite impressive gains in the prevention of traffic accidents, Illinois, as other parts of the nation, is still confronted with a dreadful toll of deaths and injuries on its streets and highways. We physicians can do much in pressing for even more rigid enforcement of our state traffic regulations, since the careless and arrogant driver recognizes only the authority of law. He has no regard for human suffering except only when another careless or arrogant driver strikes him or some member of his family down. If our present traffic laws are inadequate to cope with the speed-crazy and indifferent, then we need new and stronger laws.

The toll of accidents in our homes and factories also presents a problem of undiminished importance to the medical profession. When we physicians think in terms of preventive medicine, we should also think in terms of accident prevention, and I believe that in the future more of us will spend more of our time in doing just that.

Every accident that is avoided frees more of the physician's time and hospital service for the care of the sick, and for important research in the prevention and treatment of disease.

The profession has demonstrated in the past that it can be effective in the prevention of accidents. Thousands of lives have been saved in plants, homes, offices, and on the highways through the efforts of doctors. For a number of years physicians pressed for the installation of safety belts in automobiles. Car manufacturers have now made such belts available and traffic reports already indicate the wisdom of this move.

Although I have placed much emphasis on the prevention of accidents in the home, factory and on the highway, it is not my inten-

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*President, Illinois State Medical Society, Sherman Hotel, Friday, May* 18, 1956

tion to discount the many other medical problems which confront us.

Although great gains have been made in the field of preventive medicine, particularly during the past 25 years, we still have tremendous foes to overcome — heart disease, cancer, mental illness, and a number of other destructive diseases.

During his presidency, Dr. Norbury did much to stimulate fresh ideas pertaining to the mental health problem in Illinois. In the year ahead we must continue to pursue vigorously different approaches toward the improvement of the health and welfare of our fellow citizens.

We must also continue to press for passage of a law which would establish a coroner's system that would bring acclaim to Illinois instead of mockery. We have a serious nursing situation that must be resolved. Our excellent school health program and our splendid liaison with the Health Department must be maintained. Our work in the field of industrial health has been outstanding and should be encouraged even more.

The Illinois State Medical Society ranks as one of the largest medical associations in the nation. We may never, because of the course of geographic distribution rank as Number One in membership, but by working together as a solid unit we can rate as the *greatest* state medical organization.

It is only with your help that I can succeed as your president; without it I can accomplish nothing. Thank you again for your expression of confidence in me.

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## Social security survey completed

A majority of Illinois physicians who replied to the questionnaire on Social Security have voted against inclusion of MD's in the Old Age and Survivors Insurance program.

Survey cards were mailed to the entire membership in April by the Secretary's office at the direction of the Council. The following questions were asked:

— "Should self-employed physicians be covered under the Social Security Act?"

— "If a voluntary program is not feasible or allowed, would YOU then favor compulsory coverage?"

— "Do you favor the proposed Jenkins-Keogh bills which provide tax exemption for monies that self-employed persons use in setting up their own retirement programs?"

A total of 4,214 ISMS members took the time to indicate their preferences. This represents approximately 42 per cent of the membership. The final count shows that 2,054 physicians were opposed to any coverage under Social Security as against 1,414 who favored the program.

Not opposed to voluntary inclusion in Social Security were 654 of the respondents. There were 46 who expressed no opinion on the subject and 46 others whose answers made it difficult to determine their stand.

A separate count was made of the vote on the Jenkins-Keogh bills. Of the 4,214 physicians who replied, 3,775 voted in favor of Jenkins-Keogh and 326 voted against the proposal. This is a ratio of about 10 to 1. Indeterminate replies were given by the remaining 113 respondents.

The response that the ISMS received on its survey was good. It can safely be assumed that the results are an accurate reflection of the sentiments of all Illinois physicians.

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## Medicine on postage stamps

Recent issues of postage stamps of interest to physicians collecting medical subjects include the following:

United States—A 3c stamp picturing Dr. Harvey W. Wiley, late food and drug administrator, and commemorating the 50th anniversary of the passage of the Pure Food and Drug Act.

Belgium—A 2-franc stamp for the Red Cross, picturing a pelican feeding her young with her own blood and bearing the Flemish inscription: "Become a Blood Donor."

Costa Rica—A 40-centavos stamp in a six-value series honoring Rotary International and picturing a hospital.

Philippines—Five and 20-centavos stamps in connection with the campaign to improve conditions in rural areas initiated by President Magsaysay.

France—A 12-francs stamp honoring the Order of Malta and showing a view of a leprosarium.

Argentina—A 20-centavos plus 30-centavos stamp, the surcharge going to the Polio Fund.

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

# The Essentials of Medical Reports for Employee's Care*

Edward C. Holmblad, M.D., F.A.C.S., Chicago

THREE types of reports will be discussed — (1) report of disability due to illness of non-occupational injury; (2) report of an injury or occupational disease covered by the Workmen's Compensation Act; and (3) the report of medical evaluation examination as to present medical status.

1. A medical certificate to certify inability to work should include the following data:

NAME _____
ADDRESS _____
Diagnosis _____
Date of first treatment _____
Date of last treatment _____
Is he or she able to work? _____
If not, when can work be resumed? _____
DATE _____ _____
Signature

Sickness benefits may be denied the employee if the diagnosis is not adequate to justify inability to work. Every physician at some time or other has had a patient ask him to certify disability periods during which the patient was not under that physician's care. It is important that such certificates actually certify only the exact period that the physician treated the patient.

2. Medical reports of first treatment of compensable injuries or occupational diseases should should include the data required by the Industrial Commission in such cases and should include a history of the accident; specific and complete diagnosis; disposition of the patient, whether returned to work, home, or hospital; an estimate of the disability period and a statement as to whether disfigurement or permanent disability is anticipated.

ACCIDENT REPORT DATA

Date .....
Surname ..... First Name .....
Division ..... Address .....
Phone No. ..... Authorization .....
Age ..... Married ..... Single .....
No. of Children under 16 .....
Nationality or State where born .....
Department Employed ..... How Long .....
Occupation .....
Date of Injury ..... A.M. ..... P.M.
Date of First Attention ..... A.M. ..... P.M.
Agent or Foreman .....
Place of Accident ..... Witness .....
Patient's Account of Injury .....
Previous Injury .....
Diagnosis ..... X-Ray Findings .....
Treatment .....
Probable Disability ..... Total Recovery .....
Permanent Disability ..... Date of Release .....
Supplementary Report ..... Progress Notes .....

*This paper was prepared at the request of the Committee on Industrial Health of the Illinois State Medical Society.*

*Temporary total disability* is the inability to work (disability) which incapacitates temporarily due to illness or injury. It signifies inability to do any work at that time.

*Temporary partial disability* indicates inability to do regular work for normal working periods. Such partial disability may be either due to (1) inability to do regular work at all or (2) it may be inability to do regular work for the normal or full day's working period. In the first instance, modified work should be provided at all times, and in the second instance, shorter periods of regular work may be indicated as half days or short periods of regular work alternated with modified work periods.

*Permanent total disability* is the inability to do any work at any time with no improvement anticipated so that it is reasonable to state that the person will never be able to do any work again.

*Permanent partial disability* is the inability of the person to do regular work for regular periods of time. Again this partial disability may be inability to do (1) any regular work at any time so that modified work should be provided. Or it may be the inability of the person to do (2) regular work for more than limited periods of time. In partial permanent disability, the disabling condition is permanent with no anticipated improvements at any future time.

3. Medical evaluation examinations may be made during the period of treatment or may be made at or near the termination of treatment for the purpose of determining the following factors: Is it reasonable to terminate the temporary total disability period? (Can the patient resume work, and if so, what kind of work.) Is further treatment necessary? If so, to what extent and for what anticipated period? Determine the physical and mental medical findings that should be considered in arriving at an estimate of specific loss, or partial or total permanent disability.

Such a report should consist of: (1) opening statement; (2) history; (3) findings at examination; (4) opinion and recommendations.

*The opening statement* should give at least the name of the patient, his address, age, date and place of the examination.

*The history* covers the details of the accidental injury or the circumstances preceding the development of an occupational disease. Accidental injuries occur at a specific time and place and the mechanics of the injury may be important in determining the causative or aggravating relationship between the accidental injury and the present condition. Previous history may be limited to those items that may have a bearing on the present medical evaluation. The complete hospital type of history, chronological and by system inventory, is not practical for this type of report. It is important to relate the significant stages or events that have occurred during the treatment period such as operations, complications, period of hospitalization, and the like.

Every once in a while a patient or his attorney may refuse to give any history of the accidental injury and subsequent events. This is an unreasonable attitude because the examining physician cannot evaluate the present physical and mental condition without such information. It is true that in testifying a physician may not be permitted to testify as to the history and may be restricted to his findings at examination.

Present complaints should be listed either at the beginning or ending of the history and should enumerate these completely. Such terms as pain, weakness, limitation of motion, loss of function, disfigurement, scarring, loss of substance and inability to work may describe such complaints.

*Findings at examination* should include the results of physical examination and also the X-ray findings, special laboratory findings, and such other special studies as may have been indicated. These might be electro-encephalograms, myelograms, electrocardiograms, pulmonary function and kidney function tests.

If the accident and complaints are limited to a portion of an extremity, the examination findings can be limited to that member except when systemic disease may be associated such as diabetes, arteriosclerosis, impaired circulation, and the like.

If multiple extremity injuries or head and trunk injuries occurred, the objective findings should be described in detail. Height, weight, temperature, pulse rate, respiration, blood pressure and urinalysis should be given. Vision and hearing tests may be indicated. It is well to give an overall description of the part examined and

then go into detail as to anatomical changes, limitation of motion and tests of function and performance. Scars or other factors of disfigurement should be described, diagrammed or pictured by photographs.

X-ray reports should describe any anatomical loss of substance, all pathology such as fractures, apposition, alignment, degree of union, infection, sequestration, state of healing, and any other pathology.

Special tests should be described and interpreted such as electrocardiograms, etc.

*The opinion* should include a complete statement of the diagnosis. It should state definitely whether the healing period has terminated and whether further medical care is or is not necessary. It should give a concise statement as to the causative or aggravating relationship, if any, that exists between the injury and the present condition. It should state whether the condition has reached a state of permanency or whether any further improvement or change can reasonably be expected.

It is recognized that the estimation of specific loss or partial permanent disability is the province of the arbitrator, yet the examining physician has a right to his own opinion as to the degree of specific loss or permanent disability. Whether he will be allowed to express that opinion is another matter.

Books have been written and the literature is full of articles about disability evaluation, but it still is a difficult and controversial subject. In most states there is no difference in the disability ratings due to different occupations. An unskilled laborer rates the same disability for his fingers as an accomplished pianist, musician or highly skilled technical worker.

Each examining physician should report his diagnosis, findings and opinions as he honestly determines them by examination. It is not within his province to speculate or to misinterpret normal variations and findings as being abnormal or indicating disease or injury. An example of this would be the misreading of normal X-ray skull sutures or epiphyseal lines as fractures. It is unethical to purposely give high disability ratings in order to facilitate a compromise figure.

The evaluation or disability or the evaluation of the physical and mental status of an injured employee is an art comparable to that of the clinician in medical practice. He gains proficiency by meticulous observation, examination, experience, seasoned judgement and the writing of a concise, factual, understandable and honest medical report of his examination.

28 East Jackson Boulevard
Chicago 4, Illinois

REFERENCES

1. Medical Relations under Workmen's Compensation in Illinois.
2. A Suggested Guide for the Development of a State Workmen's Compensation Handbook for Physicians.

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## Annual otolaryngology assembly

The Department of Otolaryngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from October 1 through 7, 1956. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose and throat.

Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk Street, Chicago 12, Illinois.

# THE P. R. PAGE



RECENTLY the Public Relations Director received from the Peoria Medical Society a report on the activities which it spearheaded during Medical Education Week, April 22-28. The material was submitted by Dr. M. Thomas Gorsuch, the Society's PR chairman, who also served as chairman of the MEW Coordinating Committee in his county.

It was apparent from the report that Dr. Gorsuch and his committee did an exceptionally fine job of promoting Medical Education Week and enhancing the relationship of the medical profession to the public in their area.

The MEW Coordinating Committee in Peoria County selected as its theme for the week the slogan, "Safeguard Your Health." Although the basic objectives of Medical Education Week were kept foremost, the committee also took this opportunity to overcome some of the unfavorable publicity which Peoria had received regarding its drinking water, the incidence of alcoholism and the rise in hospital costs.

Participating in the week's activities were the society's Woman's Auxiliary, the Peoria District Dental Society, the Peoria Dental Society Auxiliary, the Peoria Voluntary Hospitals, the 7th District Illinois Nurses Association and the Central Illinois Pharmaceutical Association. Also cooperating were dietitians, clergymen, medical technicians, secretaries, record librarians, and interested nonprofessional personnel.

Thirty-seven public programs were conducted for the purpose of making Peoria area residents familiar with the community medical resources that were available through their hospitals and health organizations. From April 23 through April 27 afternoon sessions were held from 3 to 4 p.m. daily in the Methodist Hospital of Central Illinois, Proctor Community Hospital and St. Francis Hospital. They included discussions on blood banks, nutrition, pharmacy, medical records, hospital administration and laboratory work.

Three evening meetings were held. One at the Spalding Institute Gymnasium covered physical medicine and rehabilitation, another was a dinner meeting at the Pere Marquette Hotel on school health, and the last was a program at the Methodist Hospital dealing with the home care plan and alcoholism.

In addition there were two evening radio discussions over Station WIRL by members of the MEW Coordinating Committee on "Safeguard Your Health Week" and "Medical Education."

An effort to interest young people in medical and hospital careers was made through a series of Vocational Guidance Forums which were held throughout the week in the city's five high schools. To augment this program, the committee also placed six health exhibits at points throughout the city where traffic was heaviest. These exhibits dealt with the following topics: "Health Today," "Home Accidents," "Nutrition," "Immunization," "Appendicitis," and "Muscular Dystrophy."

Twenty thousand copies of a printed program, outlining the week's activities, were distributed through the cooperation of 24 clubs, banks, stores, hospitals and other agencies. These programs, combined with a vigorous newspaper publicity campaign, made Peoria area residents thoroughly aware of Medical Education and Safeguard Your Health Week. The voluminous newspaper publicity was supplemented by radio spot announcements and news items in various house publications.

Dr. Gorsuch and his MEW Coordinating Committee certainly deserve commendation for a piece of public relations work that was done thoroughly, smoothly and with greatest proficiency.

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## Vaginismus and the husband

This case led me to draw some conclusions which I later confirmed again and again. First, I observed that with few exceptions the women referred for vaginismus showed no other serious neurotic symptoms and were well able to make object relations. Secondly, I found that, where several months or even years had elapsed without the husband urging his wife to seek help, the husband might generally be assumed to be a latent homosexual. In the above case this was undoubtedly true, and my patient was deeply disappointed that when she was able to have coitus her husband showed little interest and tended to give up altogether. He, as well as some other husbands of such marriages, found compensation in work with other men, in Civil Defense, football, or similar activities. The statement of these women that their husbands are good and do not bother them should be received with dismay. Whether their choice of such partners is unconsciously motivated will need further and deeper inquiry. *Hilda C. Abraham, M.D. Therapeutic and Psychological Approach to Cases of Unconsummated Marriage. British M. J. April* 14, 1956.

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## The onset of a convulsion

A focus of irritation in the motor cortex can set off a limited convulsive seizure, which spreads by irritation, traveling along the precentral gyrus to set off adjacent cell groups until the seizure affects the whole opposite side of the body. If the seizure begins in the leg area it spreads downward to the hand and face or it may travel both up and down if it starts in the middle. In a violent attack it suddenly spreads to the other side of the body and the patient simultaneously loses consciousness. Characteristically, the attack begins in the thumb (under the thumb nail) and spreads both ways. This is because the hand is represented by a large cortical area and of the hand, the thumb is most extensively represented. There are many exceptions to this rule of start and spread, depending upon the specific site of the causative lesion. The area, gigantopyramidalis is not the only cortical area from which jacksonian seizures may be started. *J. M. Nielsen, M.D. A Textbook of Clinical Neurology.*

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## Money, money, money

As the country has grown, Federal support of various phases of education has expanded and multiplied until today it is bewildering in its extent and multiplicity. What has been the guiding principle that has directed the Federal Government into the several fields of educational activity? President Eisenhower has on many occasions referred to the philosophy of Abraham Lincoln on this point, which is: "The legitimate object of government is to do for a community of people whatever they need to have done, but cannot do at all, or cannot do so well for themselves — in their separate and individual capacities." *Alan T. Waterman. Role of The Federal Government in Science Education. Scient. Month. June* 1956.

# AT THE EDITOR'S DESK

## At the editor's desk

The latest Consumer Price Index from the U. S. Department of Labor shows that the cost of medical care rose from 108.5 in 1951 to 131.6 in April of this year. There was no change in the index for food, but rent increased from 110.6 to 131.7 and personal care from 109.8 to 119.5.

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A release from E. R. Squibb and Sons mentions their "new, well-tolerated practical hormone product for treating many pregnancy and menstrual disorders." It is marketed under the trade name Delatutin. According to the release, "Clinical trials proved that with periodic injections of Delatutin, women with unfavorable obstetrical histories of repeated abortions had a three times better chance of delivering live babies." It also was recommended in irregularities of ovarian function, premenstrual tension, painful or difficult menstruation, and female infertility.

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Parke, Davis & Company received an award from the Saturday Review for "distinguished advertising in the public interest" during 1955.

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An unusual book was published recently by Charles C. Thomas of Springfield, Illinois. It is "A Pictorial History of Medicine" by Otto L. Bettmann. The book contains over 900 pictures and 100,000 words to tell the story of medicine from Egypt to 1900. Dr. Bettmann, formerly curator of rare books, Berlin State Art Library, escaped from Germany in 1935 with $5 and steamer trunks of pictures. The Bettmann Archive in New York now is world famous and the section on medical history includes over 10,000 pictures.

The surgical appliances and supplies industry shipped products valued at $338 million in 1954, an increase of 32 per cent over 1947. This group represents establishments engaged primarily in the manufacture of surgical and orthopedic appliances and supplies and includes such items as artificial limbs, arch supports, fracture appliances, surgical gut strings, braces, sanitary napkins, and gas masks.

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We received also a news release stating that Becton, Dickinson and Company (B-D) have merged with Bard-Parker Company. Their plant operations will not be affected but they hope to benefit, however, through the consolidation of their resources and technical skills.

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The Food and Drug Administration now believes it has been successful in its campaign to shut off the illegal sales of amphetamine (stay awake pills) to truck drivers. Agents disguised as truck drivers are finding it more and more difficult to purchase these drugs.

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A new plastic, snug fitting panty for men, women, and children is now on the market. It is designed for "persons with weak bladder, bowel or discharge." A specially constructed model also is available for colostomy and ileostomy patients.

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The nation's privately supported medical schools were pleased to hear that the Ford Foundation has appointed a special committee to recommend a plan for distribution of a previously announced appropriation of $90 million.

# CORRESPONDENCE



## First inter-American conference on occupational medicine and toxicology

The University of Miami, School of Medicine, jointly with the University of Havana, School of Medicine, Cuba, will hold this year the first inter-American Conference on Occupational Medicine and Toxicology. The meeting will be held September 3 to 7. The official language of the program will be Spanish.

This year the conference will be held in Miami with the University of Miami, School of Medicine serving as host. It is expected that this Conference will be repeated next year with the University of Havana serving as host.

The program is in the hands of a committee from these two Universities. General Chairman of this year's meeting is Dr. Homer F. Marsh, Dean of the School of Medicine of the University of Miami. Co-chairmen for the University of Miami include Dr. Ralph Jones, Jr., Professor of Medicine; Dr. Willard Machle, Research Associate Professor of Pharmacology; and Dr. William B. Deichmann, Professor of Pharmacology. The committee of the University of Havana includes the following: Dr. Angel Peres Andre', Acting Dean (Vice Dean); Dr. Rafeal Penalver, Instructor in Legal Medicine and Toxicology; Dr. Vicente Pardo Castello, Assistant Professor of Dermatology; and Dr. Francisco Lancis y Sanchez, Assistant Professor of Legal Medicine and Toxicology.

The program at this time includes speakers from Venezuela, Mexico, Peru, Colombia, Chile, Puerto Rico, Cuba and the United States.

Papers to be presented include topics such as the following: "Establishment of a Medical Department in Industry," "Work and Fatigue in Industry," "Effects of Environmental Conditions on the Health of the Occupational Worker", "Recording of Medical Case Histories," "Control of Malaria in Endemic Areas," "Occupation and Heart Disease," "The Role of the Anesthesiologist in Acute Poisonings," "Neurological Problems in Occupational Medicine and Toxicology," "The Treatment of Intoxications by Organic Phosphates," "Management of Berylliosis," "Treatment of Manganese Intoxications."

The final program for this meeting is now under preparation.

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## Twenty clinics for crippled children listed for August

Twenty clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois Division of Services for Crippled Children. The Division will count 14 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 2 for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected

among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The August Clinics are:

August 1 - Hinsdale, Hinsdale Sanitarium

August 2 - Effingham, St. Anthony's Hospital

August 2 - Macomb, St. Francis Hospital

August 7 - Carmi, Carmi Township Hospital

August 9 - Elmhurst Cardiac, Memorial Hospital of DuPage County

August 9 - Springfield, St. John's Hospital

August 10 - Chicago Heights Cardiac, St. James Hospital

August 14 - E. St. Louis, Christian Welfare Hospital

August 14 - Peoria, Children's Hospital

August 15 - Alton (Rheumatic Fever), Alton Memorial Hospital

August 15 - Chicago Heights General, St. James Hospital

August 16 - Rockford, St. Anthony's Hospital

August 16 - Tuscola, Veteran Foreign Wars Hall

August 22 - Elgin, Sherman Hospital

August 22 - Springfield (Cerebral Palsy), Memorial Hospital

August 23 - Bloomington (a.m. General, p. m. Cerebral Palsy), St. Joseph's Hospital

August 24 - Chicago Heights Cardiac, St. James Hospital

August 28 - Effingham (Rheumatic Fever), St. Anthony's Hospital

August 28 - Peoria, Children's Hospital

August 30 - Litchfield, Madison Park School

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## Examinations for fellows of International College of Surgeons

Examinations for qualified fellows of the International College of Surgeons will be held in Chicago, July 23-24 and October 29-30.

Oral conferences will be held on August 6 and October 22.

For details, write to the Secretary of the Qualifications Council, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Illinois.

## Course in postgraduate gastroenterology

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at The Roosevelt in New York City, on October 18, 19, 20, 1956.

The Course will again be under the direction and co-chairmanship of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School, who will serve as surgical co-ordinator and Dr. I. Snapper, Director of Medical Education, Beth-El Hospital, Brooklyn, N. Y., who will serve as medical co-ordinator. Drs. Wangensteen and Snapper will be assisted by a distinguished faculty selected from the medical schools.

The subject matter will cover the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gall bladder, colon and rectum, with special studies of radiology and gastroscopy.

For further information and enrollment write to the American College of Gastroenterology, Department P.G., 33 West 60th Street, New York 23, N. Y.

At the Annual Meeting of the Chicago Pediatric Society, May 15, 1956, the following officers were elected for the year 1956-1957.

President: Dr. S. C. Henn, 2376 E. 71st Street, Chicago, Illinois.

Vice-President: Dr. Ralph H. Kunstadter, 664 N. Michigan Avenue, Chicago, Illinois.

Secretary: Dr. Raymond F. Grissom, 715 Lake Street, Oak Park, Illinois.

Treasurer: Dr. Noel Shaw, 636 Church Street, Evanston, Illinois.

Editor: Dr. Howard Traisman, 6354 N. Broadway, Chicago, Illinois.

Executive Committee: Dr. Alfred Traisman, Dr. Eugene T. McEnery, and Dr. Maxwell P. Borovsky.

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# NEWS of the STATE



## ADAMS

**Medical Public Relations.**—Leo Brown, Director of Public Relations of the American Medical Society, addressed the Adams County Medical Society at its annual public relations meeting, May 14, on "The American Medical Association Public Opinion Studies." The meeting was in charge of the society's public relations committee, comprising Drs. Newton DuPuy, Paul T. Lambertus, Robert C. Murphy, Hilliard M. Shair and Harold Swanberg.

**Personal.**—Drs. Walter Stevenson and Orville Graves, Jr., announce the removal of the Stevenson Eye Clinic to 1124 Broadway, Quincy.

## CLINTON

**Physicians and Dentists Meet.**—A joint meeting of the physicians and dentists formed the regular monthly session of the Clinton County Medical Society in Breese, June 13. Speakers were Drs. Norman J. Rose and Orvis S. Hoag. Their subjects, respectively, were "Newer Concepts and Tests for Biologically False Positive Reactions in Suspected Cases of Syphilis" and "Dental Health Problems of the Aging."

## COOK

**Public Meeting on Diabetes.**—On June 7 the Chicago Diabetes Association sponsored its annual spring meeting for the public. Speakers were Drs. Charles H. Best, Toronto, Past, Present and Future of Diabetes; Francis D. W. Lukens, Philadelphia, Oral Insulin Substitutes; Alexander Marble, Boston, Complications of Diabetes, and Blair Holcomb, Portland, Ore., Living with Diabetes.

**Moorhead Memorial Lectureship.**—Dr. Max S. Sadove, chairman of the division of anesthesiology, University of Illinois College of Medicine, gave the annual L. D. Moorhead Memorial Lecture, May 16, under the joint auspices of Stritch School of Medicine of Loyola University and Phi Beta Pi Fraternity. His subject was "The Changing Scene in Anesthesia."

**Alumni Reunion.**—New officers chosen at the Michael Reese Hospital Alumni Reunion, June 13, are Drs. Bernard N. Cohen, president; Philip A. Daly, Champaign, vice president; Arno Leshin, treasurer, and Jerome M. Silver, secretary. Morning clinics featured the program of the Annual Reunion. At the banquet in the evening, Dr. Norman Leshin, chairman of the department of ear, nose and throat, acted as master of ceremonies. Dr. Sidney Strauss was guest of honor in recognition of his years of service as a member of the staff of Michael Reese.

**Physiologist Honored.**—Carlos I. Reed, Ph.D., retiring professor of physiology at the University of Illinois College of Medicine, was honored at a banquet, June 6, given by 120 fellow staff members and former students. Dr. Reed's retirement marks the end of twenty-eight years of service at Illinois. According to the Chicago Tribune, gifts presented Dr. Reed included a travel bag from the sophomore class, a radio from the freshmen, and a bound volume of letters from associates and ex-students testifying to his teaching ability and to the stimulus he has been to research in general physiology, arthritis and nutrition.

**Howard Lindberg Heads Medical Staff at Passavant.**—Dr. Howard A. Lindberg, assistant professor of medicine at Northwestern University Medical School, was installed as president of the medical staff of Passavant Memorial Hospital, June 5, succeeding Dr. James K. Stack. Dr. John I. Brewer, professor of obstetrics and gynecology at Northwestern, was named president-elect.

**Martin Luken Honored at Pontifical Mass.**—The fiftieth anniversary of Dr. Martin G. Luken as a member of the staff of St. Elizabeth's Hospital was observed at a pontifical mass, June 7, and in the evening at a banquet. Dr. Luken's service to the hospital began in 1906 with his internship, following his graduation at the University of Illinois College

of Medicine. In addition, the medical library at the hospital was dedicated in his honor. Staff members presented a gold inscribed memento and a plaque, and sisters at the hospital presented Dr. Luken with a gold key.

**Past President Vaughn Honored.**—Dr. Arkell M. Vaughn, professor of surgery, Stritch School of Medicine of Loyola University and Past President of the Illinois State Medical Society, was made an honorary member of the Hollywood (Calif.) Academy of Medicine, May 10. Dr. Vaughn addressed the academy on "Diagnosis and Treatment of Diverticulitis of the Colon."

**Stillians Lecture.**—Percy L. Julian, Ph.D., Director of the Julian Laboratories, Inc., delivered the Sixth Arthur William Stillians Lecture before the Metropolitan Dermatological Society of Chicago, May 9. His subject was "Some Intriguing Potentials in Steroid Hormone Researches."

**The Healing of Wounds.**—Newer Findings and Concepts in the Healing of Wounds was the theme of three lectures developed by the department of biochemistry of Stritch School of Medicine of Loyola University. Speakers were: Leon Edwards, department of surgery, Harvard University Medical School, Boston, May 8, on "Role of Methionine in Wound Healing During Protein Starvation"; Dr. David S. Jones, department of anatomy at Stritch, May 15, "Healing of Muscle Tissue", and Hubert R. Catchpole, Ph.D., department of pathology, University of Illinois College of Medicine, May 22, "The Ground Substance of Connective Tissue in Healing Wounds."

**Annual Award to Honor Slain Intern.**—The Dr. Bruno Epstein Intern Achievement Award has been established in honor of the intern who was slashed to death by a psychotic patient at Cook County Hospital recently. The award will be sponsored jointly by Hektoen Institute and the Phi Delta Epsilon Foundation. A plaque or certificate and a cash prize will be granted each year to one or more interns for meritorious service in the care of hospital patients, the Chicago Daily News reported.

**Tuberculosis Sanitarium Approved for Residency Training.**—The Chicago State Tuberculosis Sanitarium was recently approved for the residency training of physicians in the special field of pulmonary diseases. This approval came from the American Medical Association's Council on Medical Education and Hospitals in concurrence with the Subspecialty Board on Pulmonary Diseases of the American Board of Internal Medicine. As early as July 1955, the sanitarium received approval of its residency program in the field of thoracic surgery. Again in cooperation with the Council on Medical Education and Hospitals, this approval came from the American Board of Thoracic Surgery. The Chicago State Tuberculosis Sanitarium, operated by the Illinois Department of Public Health, was opened in October 1953. According to the Illinois Health Messenger for May, the bed occupancy is about 275.

## DuPAGE

**Membership Status.**—Drs. Paul Oberschneider, Roselle, Valdo P. Oleari, Wheaton, and Richard J. Schilling, Clarendon Hills, are new members of the Du Page County Medical Society. As of May 1, one hundred and fifty-four members of the society showed 100 per cent payment of dues. The society has one resident member; eight retired or Past Service members; seven in government service. Eleven non-members are practicing in DuPage County, and ninety-one members have Blue Cross insurance through the society. The society is considering a plan to establish a fund whereby the widow or next of kin of a deceased member would, within a few hours of the death of the member, receive a sum of money in cash. Dr. Elvin L. Seiderlin, Wheaton, formerly health officer, has moved to Helena, Montana, and Dr. Alfred J. Lepak has discontinued his office in Wheaton. Dr. Joseph W. Krystosek, Lombard, recently received a commendation from the DuPage County Department of Welfare for his development of a new physician statement form which is now used throughout the state of Illinois.

## LAKE

**Personal.**—Dr. Alfred J. Dowe, 720 South Wolcott Avenue, Chicago, has been accepted into membership in the Lake County Medical Society. As of June 1, the society had 158 members; of this number four are emeritus members and three are Past Service members.

## MACON

**Fifty Years of Practice.**—Drs. C. E. Woodward and Otis O. Stanley, both of Decatur, were inducted into membership in the Fifty Year Club of the Illinois State Medical Society, May 22, at a meeting of the Macon County Medical Society. Both were presented with pins and certificate signifying membership in the Club. The physicians were classmates at Northwestern University Medical School where they graduated in 1906.

## McDONOUGH

**Fifty Years of Practice.**—Drs. A. P. Standard and George S. Duntley, both of Macomb, were given the gold pin and certificate signifying membership in the Fifty Year Club of the Illinois State Medical Society and marking completion of fifty years in the practice of medicine. Presentation was made by Dr. Charles P. Blair, Monmouth, Councilor of the Fourth District of the state medical society. The ceremony was a feature of the meeting of the McDonough County Medical Society, April 24. The society went on record to endorse the fluoridation of water.

## ST. CLAIR

**Tumor Detection Clinic.**—The operation of a Cytology Tumor Detection Clinic is now under way at Christian Welfare Hospital, East St. Louis.

The clinic is subsidized by the Illinois State Department of Public Health. Since its opening, there have been between twelve and sixteen patients each clinic period from 8:30 a.m. to 9:30 a.m. each Friday. The patient is admitted with a referral slip from her physician and advised to contact him in two weeks for a report on the clinic's slide examination.

**Dr. Renner Honored.**—Dr. Frederick A. Renner, Lebanon, was inducted into the Fifty Year Club of the Illinois State Medical Society, May 3, at a dinner meeting of the St. Clair County Medical Society in Pleasant View Sanatorium. Dr. Renner, who graduated at St. Louis University Medical School, St. Louis, practiced for fourteen years in Benld and for thirty-seven years in Lebanon. Presentation of the gold pin and certificate, emblematic of membership in the Fifty Year Club, was made by Dr. Willard W. Fullerton, Sparta, Councilor of the Tenth District of the Illinois State Medical Society.

## SANGAMON

**Society News.**—The Sangamon County Medical Society was addressed in the Elks Club, Springfield, June 7, by Drs. James M. Furrie on "Surgery in Metastatic Carcinoma"; Gershom K. Greening, "Clinical Uses of Transaminase," and J. A. Stocker, "Dysphagia Vasorum."

## WINNEBAGO

**Personal.**—Col. Roland I. Pritikin, M.C., U.S.A.R., Rockford, recently returned from a lecture tour of hospitals and medical schools of Asia. He attended the Sixth Middle East Medical Assembly in Beirut, Lebanon (Campus-American University of Beirut) as official delegate of the American Medical Association, International College of Surgeons, Industrial Medical Association, Association of Military Surgeons of the United States, and the International Organization Against Trachoma. Dr. Pritikin was also the official observer for the World Medical Association.

**Personal.**—Dr. Fred Newman Smith, 1421 Camp Avenue, Rockford, is a new member of the Winnebago County Medical Society; he is associated with Dr. John H. Laubscher.

## GENERAL

**Medical Secretaries and Assistants Form Group.**—The Illinois State Medical Secretaries and Assistants Association was organized at a meeting in the Leland Hotel, Springfield, June 3. The Adams County Medical Secretaries and Assistants Club, sponsored in 1951 by the Adams County Medical Society, Quincy, and the Swanberg Medical Foundation of the society, sponsored the formal organization of the state group. Officers include Miss Dorothy Hoffstadt, 1101 Maine Street, Quincy, president; Mrs. Elberta Fischer, Chicago, president-elect, and Miss Thelma Newberry, 1101 Maine Street, Quincy, secretary. The first annual meeting will be in Quincy in April 1957. The constitution adopted by the new organization was drafted by the Swanberg Medical Foundation and submitted for approval to the Secretary and several Councilors of the Illinois State Medical Society.

**National Organization Renamed.**—The American Academy of Obstetrics and Gynecologists has been renamed the American College of Obstetricians and Gynecologists, effective May 11. Headquarters of the College are at 116 South Michigan Avenue, Chicago 3.

**Anesthetists Choose Officers.**—Dr. James A. Felts, Marion, was chosen president-elect of the Illinois Society of Anesthesiologists, May 13, and Dr. Bernard Stodsky, Chicago, was installed as president. Other officers are Drs. Harold L. Harris, Evanston, vice president; Ernest F. Kreutzer, Joliet, secretary, and Morris J. Finer, Brookfield, treasurer.

**"Your Doctor Speaks" on FM Station WFJL.**—The following physicians have recently appeared in transcribed broadcasts of **FM Station WFJL, Thursday evenings at 7:45 p.m.** The series, entitled "Your Doctor Speaks" is presented by the **Educational Committee** of the **Illinois State Medical Society:**

**Paul J. Dunn,** clinical instructor in pediatrics, Stritch School of Medicine of Loyola University, June 7, They Are What We Make Them.

**A. Beaumont Johnson, II,** assistant attending neurosurgeon at Presbyterian Hospital, June 14, on Injuries of the Head and Spine.

**"WMAQ Presents."—F. Lee Stone,** President of the Illinois State Medical Society, and **Walter H. Theobald,** President of the Medical Center Commission, appeared in a transcribed broadcast on WMAQ, Monday evening, June 11, at 9:30 p.m. Title of the program is WMAQ Presents. The physicians discussed "Chicago as a Medical Center" and appeared under the auspices of the **Educational Committee** of the **Illinois State Medical Society.**

**Lectures Arranged Through the Scientific Service Committee** of the **Illinois State Medical Society:**

**Robert J. Patton,** attending surgeon, Memorial and St. John's Hospitals, Springfield, Montgomery and Macoupin County Medical Societies, June 20, in Litchfield, on A Hazard of Antibiotics in Surgery.

**Walter Oblinger, LL.B.,** Associate Counsel for the Illinois State Medical Society, La Salle County Medical Society in Ottawa, June 21, on Medico-legal Aspects of Medical Testimony.

**Gershon K. Greening,** Springfield, Jackson County Medical Society in Murphysboro, June 26, on Electrolytes and Fluid Balance.

## DEATHS

**Hugh Pierce Barton,** Chicago, who graduated at Northwestern University Medical School in 1910, died April 12, aged 70, of coronary occlusion and arteriosclerosis.

**Robert R. Bensley,** retired, Chicago, who graduated at the University of Toronto Faculty of Medicine, Ontario, Canada, in 1892, died June 11, aged

89. He was professor emeritus of anatomy at the University of Chicago.

**William H. Bradley***, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1910, died May 25, aged 73. He was formerly a member of the staff of St. Anthony of Padua Hospital.

**Benjamin Braude***, Chicago, who graduated at Rush Medical College in 1909, died May 16, aged 69. He was attending physician at Franklin Boulevard Community Hospital.

**Isidore Brill***, Champaign, who graduated at the Chicago Medical School in 1938, died April 29, aged 48.

**Harry R. Feldott***, Hinsdale, who graduated at Loyola University School of Medicine in 1918, died May 27, aged 61. He was a member of the staff of the Hinsdale Memorial Hospital for 35 years.

**Siegfried Gruenwald***, Alton, who graduated at Medizinische Fakultät der Universität, Wien, Austria, in 1920, died May 6, aged 64.

**Frederick J. Hamlin**, Peoria, who graduated at the Hahnemann Medical College and Hospital in 1901, died February 21, aged 80. He was suffocated in his smoke-filled apartment after the building caught fire, apparently from an overheated coal stove.

**Frank B. Harmison***, retired, who graduated at Rush Medical College in 1896, died June 10, aged 86. He served for 25 years in the contagious disease department of the Chicago Board of Health.

**Nicholas Anton Herrmann***, Harrisburg, who graduated at Loyola University School of Medicine in 1921, died near Lake Wales, Florida, February 28, aged 59, of injuries received in an automobile accident. He was president of the Saline County Medical Society and a member of the staff of the Lightner Hospital.

**Erwin S. Hottinger**, Chicago, who graduated at Northwestern University Medical School in 1906, died May 31, aged 72. He had served as physician for the Western Medical Corporation since 1943.

**George H. Jackson, Jr.***, Evanston, who graduated at Harvard Medical School, Boston, in 1918, died April 11, aged 66.

**Alfred Leimdorfer**, Chicago, who graduated at Medizinische Fakultät der Universität, Vienna, Austria, in 1910, died April 9, aged 68, of coronary thrombosis. He was research professor of pharmacology at Stritch School of Medicine of Loyola University.

**Frederick A. Lofton***, Chicago, who graduated at Harvey Medical College in 1901 died June 9, aged 83. He was one of the original members of the staff of St. Bernard's Hospital.

**Marcus L. Manley***, Chicago, who graduated at Creighton University School of Medicine, Omaha, in 1923, died May 9, aged 56. He was a member of the staff of the Little Company of Mary Hospital.

**Alfred J. Massover***, Chicago, who graduated at Rush Medical College in 1940, died June 12, aged 43. He was a major in the army medical corp in World War II.

**James J. McCarty**, Jr., Chicago, who graduated at Harvard Medical School, Boston, in 1913, died May 28, aged 71.

**John F. McNamara***, retired, Chicago, who graduated at Loyola University School of Medicine in 1921, died May 29, aged 67. He was former senior surgeon at Mercy Hospital.

**Albert W. Moore***, Aurora, who graduated at the College of Physicians and Surgeons of Chicago in 1893, died February 8, aged 94, of myocardial degeneration. He had served as a member of the staff of St. Charles Hospital.

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*Member, Illinois State Medical Society.



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*complains that the pain*

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*Smith, Kline & French Laboratories, Philadelphia*

1. Howell, T.H., et al.: Practitioner *173*:172 (Aug.) 1954.

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'Thorazine' should be administered discriminately; and, before prescribing, the physician should be fully conversant with the available literature.

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

ARTERIOSCLEROSIS. A symposium presented by The Minnesota Heart Association and the University of Minnesota. September 7, 8 and 9, 1955. Edited by Ancel Keys, Director, Laboratory Physiological Hygiene, University of Minnesota.

PEER GYNT — Henrik Ibsen — A dramatic poem in five acts. A new translation by Horace Maynard Finney, M. D. Philosophical Library, New York. $3.75.

THE MENNINGER STORY. By Walker Winslow. Doubleday & Company, Inc., N. Y. 22, N. Y. $5.00.

MANAGEMENT OF STROKES. By Keith W. Sheldon, M.D. J. B. Lippincott Company, Philadelphia and Montreal. $3.00.

THRESHOLDS OF EXISTENCE—A Cosmogony and Theory of Evolution as a Way of Life. By Upton Clary Ewing. Philosophical Library, New York. $3.75.

NEW AND NONOFFICIAL REMEDIES—containing descriptions of drugs evaluated by the Council on Pharmacy and Chemistry of the American Medical Association, 1956. An annual publication issued under the direction and supervision of the council. J. B. Lippincott Company, Philadelphia and Montreal.

DISEASES OF THE NOSE, THROAT AND EAR—a handbook for students and practitioners. By I. Simson Hall, M.B., Ch.B., F.R.C.P.E., F.R.C.S.E., surgeon to the Royal Infirmary, Edinburgh. 8 colored plates. Sixth edition E. & S. Livingstone Ltd., Edinburgh and London, 1956. $4.75.

THE YEARBOOK OF MODERN NURSING, 1956—a source book of nursing. Editor, M. Cordelia Cowan, Nursing Educator, author, and editor. Foreword by Mary M. Roberts, Editor Emeritus, American Journal of Nursing. G. P. Putman's Sons, New York.

PREFACE TO EMPATHY. By David A. Stewart. Philosophical Library, New York. $3.75.

HUNTERDOM MEDICAL CENTER—the story of one approach to rural medical care. By Ray E. Trussell. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1956. $3.75.

MENTAL HEALTH PLANNING FOR SOCIAL ACTION. By George S. Stevenson, M.D., Sc.D., National and International Consultant, The National Association for Mental Health, Inc. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, Toronto, London, 1956. $6.50.

A DICTIONARY OF DIETETICS. By Rhoda Ellis, Ph.D., Instructor of Foods and Nutrition, Department of Home Economics, Brooklyn College, New York. Philosophical Library, New York, New York. $6.00.

HISTAMINE. Ciba Foundation Symposium, jointly with The Physiological Society and the British Pharmacological Society on Histamine, in honor of Sir Henry Dale, O.M., G.B.E., M.D., F.R.C.P., F.R.S. Editors for the Ciba Foundation, G. E. W. Wolstenholme and Cecilia M. O'Connor. 133 illustrations. Little, Brown and Company, Boston, 1956. $9.00.

SYPNOSIS OF GYNECOLOGY. Based on the textbook, "Diseases of Women". By Robert James Crossen, M.D., F.A.C.S., Associate Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine. Fourth edition. 132 illustrations including frontispiece in color. The C. V. Mosby Company, St. Louis. $5.25.

HEALTH OBSERVATION OF SCHOOL CHILDREN. A guide for helping teachers and others to observe and understand the school child in health and illness. By George M. Wheatley, M.D., M.P.H., Third Vice-president, Health and Welfare, Metropolitan Life Insurance Company and Grace T. Hallock, Co-author of Health for Better Living series, Understanding Health, Health Heroes Series, and other health books. Illustrations by Barbara Pfeiffer. Second edition. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, Toronto and London. $6.50.

HEALTH AND TRAVEL. Proceedings of the First International Symposium on Health and Travel, held in New York City, June 23, 1955. Chairman: Felix Marti-Ibanez. M. D. Publications, Inc., New York, New York.

MEDICAL WRITING. By Walter C. Alvarez, Hugh Clegg, Felix Marti-Ibanez, Hans Selye and Henry E. Sigerist. M. D. Publications, Inc., New York, New York.

THE NEUROSES IN CLINICAL PRACTICE. By Henry P. Laughlin, M.D., Assistant Clinical Professor of Psychiatry, George Washington University School of Medicine; Head, Psychiatry and Neurology Division, Suburban Hospital, Bethesda, Maryland; Consultant in Psychiatry, Walter Reed Army Medical Center. 802 pages. W. B. Saunders Company, Philadelphia and London, $12.50.

THE OFFICE ASSISTANT IN MEDICAL OR DENTAL PRACTICE. By Portia M. Frederick, Instructor, Medical Office Assisting, Long Beach City College and Carol Towner, Executive Assistant, Department of Public Relations, American Medical Association. 351 pages. 55 figures. W. B. Saunders Company, Philadelphia and London, $4.75.

THE MANAGEMENT OF MENSTRUAL DISORDERS. By C. Frederic Fluhmann, B.A., M.D., C.M., Clinical Professor of Obstetrics and Gynecology, Stanford University School of Medicine, San Francisco. 350 pages. 121 figures. W. B. Saunders Company, Philadelphia and London. $8.50.

DISEASES OF THE SKIN. By Richard L. Sutton Jr., A.M., M.D., F.R.S. (Edin.) Chairman of the Department of Dermatology, University of Kansas Medical Center, Eleventh Edition. 1972 illustrations. The C. V. Mosby Company, St. Louis, $29.50.

to prevent anginal attacks—

*which will you prescribe next time?*



**4 hour protection**

*1 PETN Tablet (pentaerythritol tetranitrate)*

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Now, for the first time, you can protect anginal patients with *Pentritol's* uninterrupted prophylaxis. One Pentritol Tempule on arising and a second twelve hours later maintains coronary vasodilation 24 hours a day. This continuous protection was virtually impossible with 4-hour tablets of PETN. Pentritol prevents attacks which were precipitated by medication-gap. Your patients' response to uninterrupted prophylaxis will demonstrate the advantages of Pentritol.

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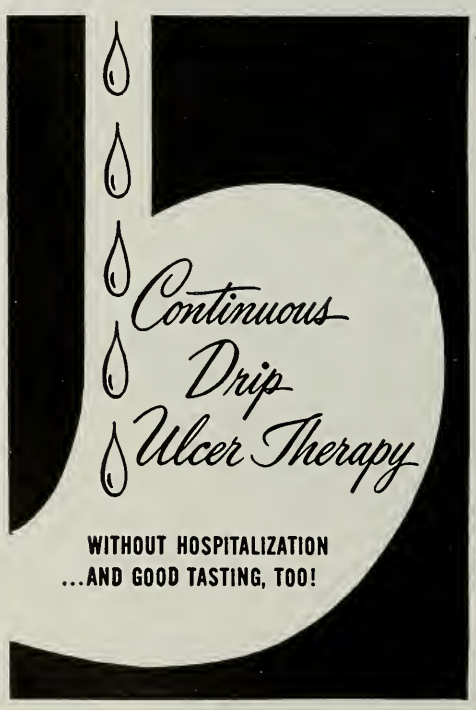
the Evron company, 354C Clark, Chicago 13, Ill.

## Sex determination

The discovery that genetic sex can be diagnosed on the presence of chromatin masses in female nuclei in human tissues suggested that this test might be applied to diagnosis of the sex of the fetus before birth. Accordingly, 20 specimens of liquor amnii were obtained between the 26th and 42nd weeks of gestation by artificial rupture of the membranes or at cesarean section, and the centrifuged deposit was examined after staining. The sex of the fetus was correctly diagnosed in 18; the two others were unsuitable for accurate prediction. To test the practicability of using this method to determine the sex of the fetus before birth, 20 other patients were selected for abdominal paracentesis between the 32nd and 36th weeks of pregnancy. Only 13 suitable samples of liquor amnii were obtained, and the sex of the fetus was predicted correctly in all—six male and seven female. In the remaining seven cases, no liquor was obtained at all from three, a small amount of bloody fluid from three, and pure blood from one. One of these patients went at once into premature labor at 36 weeks' gestation. Although these incidents were not followed by serious consequences they seem to indicate that the method involves a small risk, mainly to the fetus, and is therefore unsuitable for general use to discover a child's sex which would soon be known for certain. *C. J. Dewhurst. M.B. Diagnosis of Sex before Birth. Lancet, April* 21, 1956.

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Mortality is not the real yardstick to measure the importance or judge the control of a disease. Even if there were drugs capable of preventing the sudden deaths resulting from hypertension and arteriosclerosis, these conditions would remain a tremendous medical and social problem. Similarly, adults do not commonly die of mental disorders, arthritis, or peptic ulcers. Yet, no one would claim that these afflictions have been conquered. Neither has tuberculosis been conquered. Instead, the forces which have been at work during the past century have slowly converted it from a killing to a chronic disease. Rene J. Dubos, Ph.D., Nat. Tuberc. A. Tr., May, 1954.


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# Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

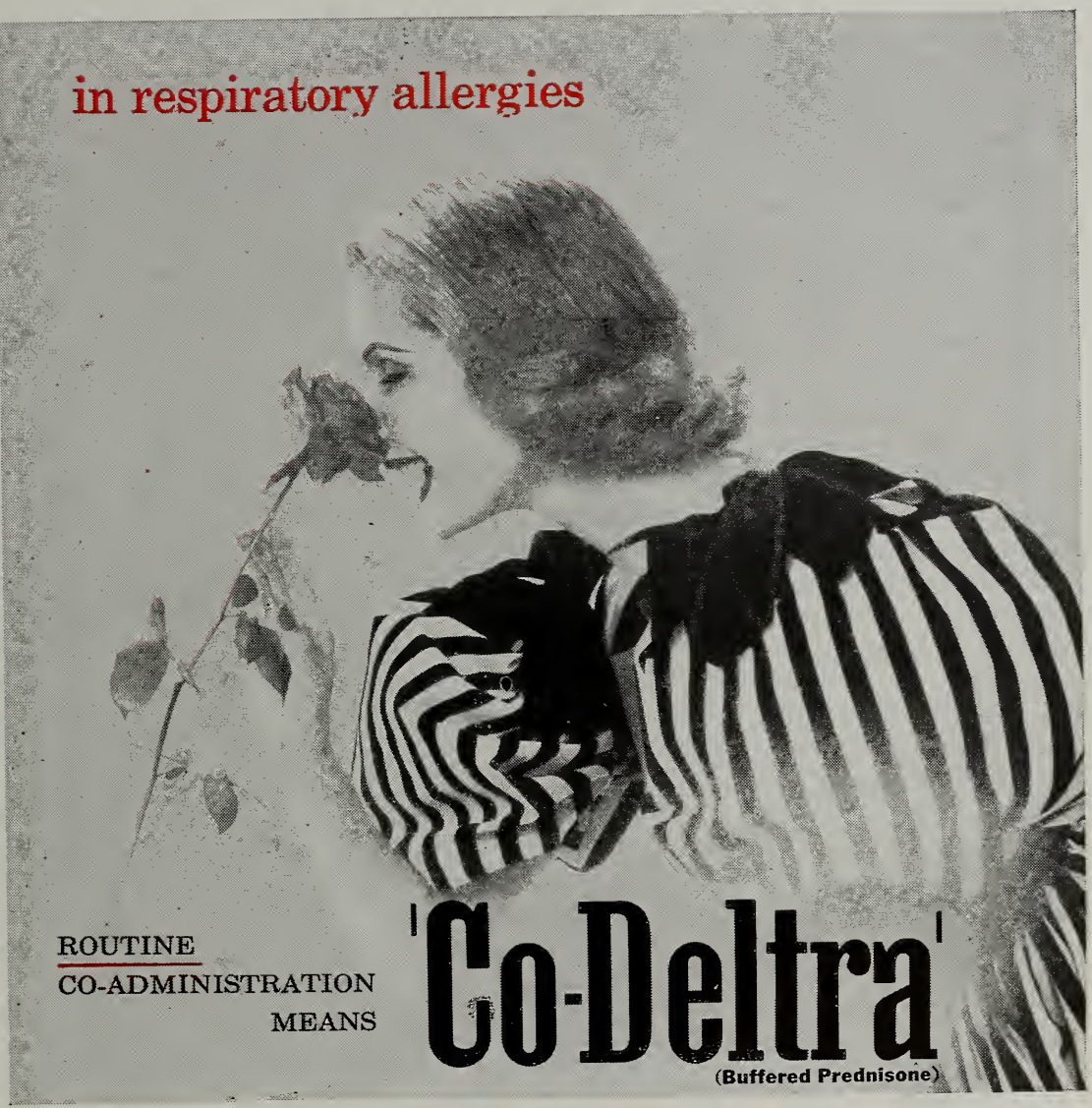
The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

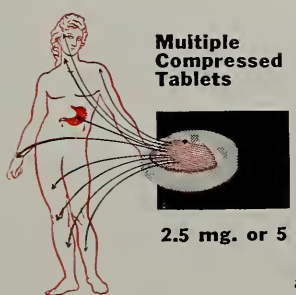
in respiratory allergies



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(Buffered Prednisone)

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Multiple Compressed Tablets

Clinical evidence[1, 2, 3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

**2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.**

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*References:* 1. Boland, E. W., *J.A.M.A.* **160**:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* **158**:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* 158:459, June 11, 1955.

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ALL THE BENEFITS OF THE "PREDNI-STEROIDS" PLUS POSITIVE ANTACID ACTION TO MINIMIZE GASTRIC DISTRESS

## Colon cytology

The colon is another site where cytology might be a great help, though the important cells are sometimes out of reach. Wisseman et al. and Bader and Papanicolaou have shown that diagnosis by this method is feasible when the lesion lies in or distal to the descending colon. Fecal detritus is an obvious hindrance which can be eliminated only by preliminary purgation and enemata. The method of collection is by washing rather than by direct smears from secretions. Rubin et al. have shown that cytology can determine the significance of a filling defect seen on barium enema which may be either a Crohn's lesion, diverticulitis, or carcinoma. Galambos and Klayman have had similar experiences; moreover, their negative findings were significant, for cancer was ultimately excluded in 32 patients with colonic symptoms, though in five a radiological diagnosis of cancer had been made. Cytological examination showed no malignant cells in any of the 32. Having had no false positives, they state categorically that the presence of malignant cells is conclusive evidence of a malignant lesion, and from their positive results in 26 patients, they were even able to diagnose correctly a metastatic ovarian deposit. Cytology would have special application in ulcerative colitis since malignant change may be hard to detect either clinically or radiologically; a positive cytological report in the longstanding case would tip the scale in favor of surgery despite the absence of other indications of malignancy—and carcinomatous degeneration in this disease is by no means inevitably fatal if taken early. There is, however, one difficulty for the diagnostic cytologist in this disease since large columnar cells are sometimes seen which simulate certain types of malignant cells. The presence of undifferentiated malignant cells, however, may be regarded as reliable evidence of cancer, according to Galambos et al. He and his co-workers also indicate that these large columnar cells are worth further study because of their similarity to the large gastric cells of addisonian anemia which, like ulcerative colitis, carries an increased incidence of malignant degeneration. Could these cells, therefore, represent a metaplastic reflection of the malignancy to come? *Editorial. Cancer Cytology. Lancet, April* 21, 1956.


*For the Aged and Senile Patient*




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Metrazol, a centrally acting stimulant, increases respiratory and circulatory efficiency without overexcitation or hypertensive effect.

Dose: 1½ to 3 grains, 1 or 2 teaspoonfuls Liquidum, or the tablets, every three or four hours.

Metrazol tablets, 1½ grs. (100 mg.) each. Metrazol Liquidum, a wine-like flavored 15 per cent alcoholic elixir containing 100 mg. Metrazol and 1 mg. thiamine HCl per teaspoonful.

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"Many older persons suffer from hypoproteinemia. This may manifest itself clinically as fatigue, secondary anemia, edema, or lowered resistance to infections." N. Jolliffe, F. F. Tisdall, P. R. Cannon; Clinical Nutrition, Paul B. Hoeber, Inc., 1950, p. 681.

*(Complete formula together with amino acid, vitamin and mineral assays will be sent on letterhead requests.)*

## Physician strike

On August 25-26 of last year, there was an event in Austria which should be of interest to every practicing physician. On these dates the medical and dental professions of Austria staged a protest strike against the present system of practice in that country. They finally told the public by open rebellion how they disapproved of a system of socialized medicine in which they now find themselves helpless pawns. On these two days the doctors and dentists closed their offices, saw no patients, did no surgery, and signed no death certificates or other papers. Only for emergency cases was provision made. They gathered and marched by the hundreds down the streets of Vienna wearing their characteristic long white coats, carrying banners informing the public of the reasons for the strike. Handbills were passed out, public address systems and placards on every doctor's office told their story. The newspapers carried front page pictures and headlines. They asked only for a square deal and freedom to practice their profession. *Editorial. Austrian Doctors Strike. Arizona Med. March* 1956.

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## Never give up

Although the problem of the chronically ill and disabled aged is recognized as one of the leading challenges of our times, a despairing therapeutic attitude on the part of the physician is prevalent too often. This defeatist resignation is especially manifested in cases of hemiplegia. For the one million hemiplegics in the United States today, the physician's responsibility cannot end when the acute phase of the treatment has been cared for. The physician who fails to see that the hemiplegic under his care receives the full benefit of modern methods of rehabilitation and retraining is in the same category as the physician who persists in using dietary restrictions alone in the management of diabetes when insulin is available. *Gulden Mackmull, M.D. Salvaging the Hemiplegic Patient. Pennsylvania M. J. April* 1956.





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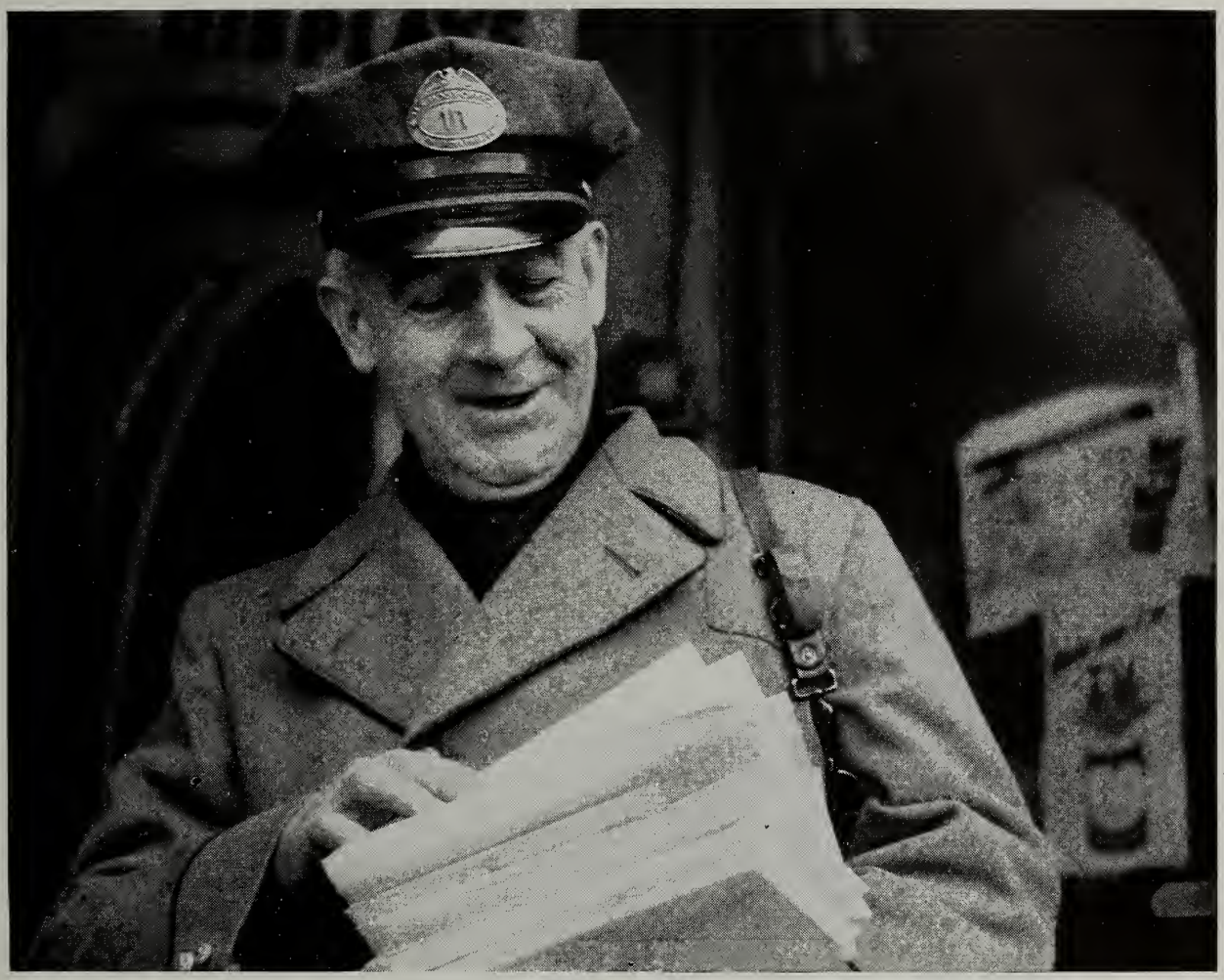
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For persons past forty, good health is usually a source of great pride and satisfaction. Each succeeding year seems to heighten their delight and appreciation. To help these "senior citizens" maintain their vigor, prescribe GEVRAL, a comprehensive geriatric diet supplement that provides 14 vitamins, 11 minerals, and Purified Intrinsic Factor Concentrate—all in one convenient, *dry-filled* capsule.

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| Vitamin $B_{12}$ | 1 mcgm. | Ascorbic Acid (C) | 50 mg. | Boron (as $Na_2B_4O_7.10H_2O$) | 0.1 mg. |
| Thiamine Mononitrate ($B_1$) | 5 mg. | Vitamin E (as tocopheryl acetates) | 10 I.U. | Copper (as CuO) | 1 mg. |
| Riboflavin ($B_2$) | 5 mg. | Rutin | 25 mg. | Fluorine (as $CaF_2$) | 0.1 mg. |
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| Folic Acid | 1 mg. | Iron (as $FeSO_4$) | 10 mg. | Magnesium (as MgO) | 1 mg. |
| Pyridoxine HCl ($B_6$) | 0.5 mg. | Iodine (as KI) | 0.5 mg. | Potassium (as $K_2SO_4$) | 5 mg. |
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Other Lederle geriatric products include: *GEVRABON** Vitamin-Mineral Supplement Liquid with a wine flavor; *GEVRAL*[A] Protein Vitamin-Mineral-Protein Supplement Powder; and *GEVRINE** Vitamin-Mineral-Hormone Capsules.

## Automation and you

Automation will require that all physicians — those in private practice as well as those in industry — know much more about the tolerance of the human organism to the stresses of occupation. The man-machine relationship must be studied carefully by both the physician and the design engineer in order to achieve the most efficient and beneficial use of human capacities and skills. Despite the fact that man will be required less and less to work jointly with a machine in the production of goods, the need for attention to the stress-strain problems of man at work, in planning the work facilities and the working environment is not eliminated. Instrument dials and other control panel components at which the employee in the automatized industry will work must be designed with the physiological capacities of the man in mind. Boredom and fatigue can be caused by improper eye co-ordination, and this is only one of the factors involved.

Automation is not going to have the effect of an atomic bomb falling on us. On the contrary, it will mean greater enjoyment of life, and will make possible a greater humanization of industry. The working environment will undoubtedly be a safer, healthier place, and many of the hazards will be completely eliminated. Any new medical problems which arise can be coped with by adhering to the principles of preventive medicine, utilizing the knowledge and techniques of industrial health specialists in all the professional fields. *C. Richard Walmer, M.D., Medical Aspects of Automation. J. Indust. Med., May* 1956.

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## Origin of physician

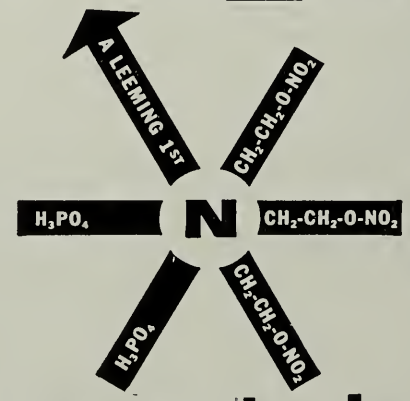
The physician derives his name from the Greek word, physis, or nature; and the Greek term, physike meant a knowledge of nature. Included under nature were all of the natural sciences including biology and medicine. Because the teaching of medicine came under the general heading of physicus, the practitioners of this natural science became known as physicians. The term came into English via the French in about the 13th century. *Harry Wain, M.D. The Story Behind the Word. Ohio M. J. March* 1956.


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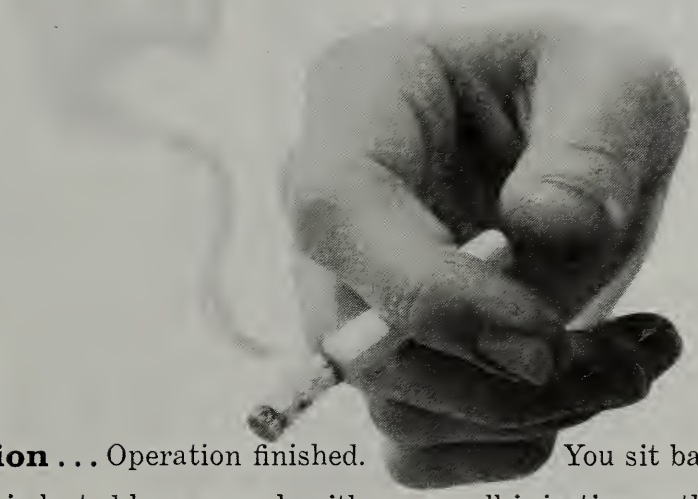
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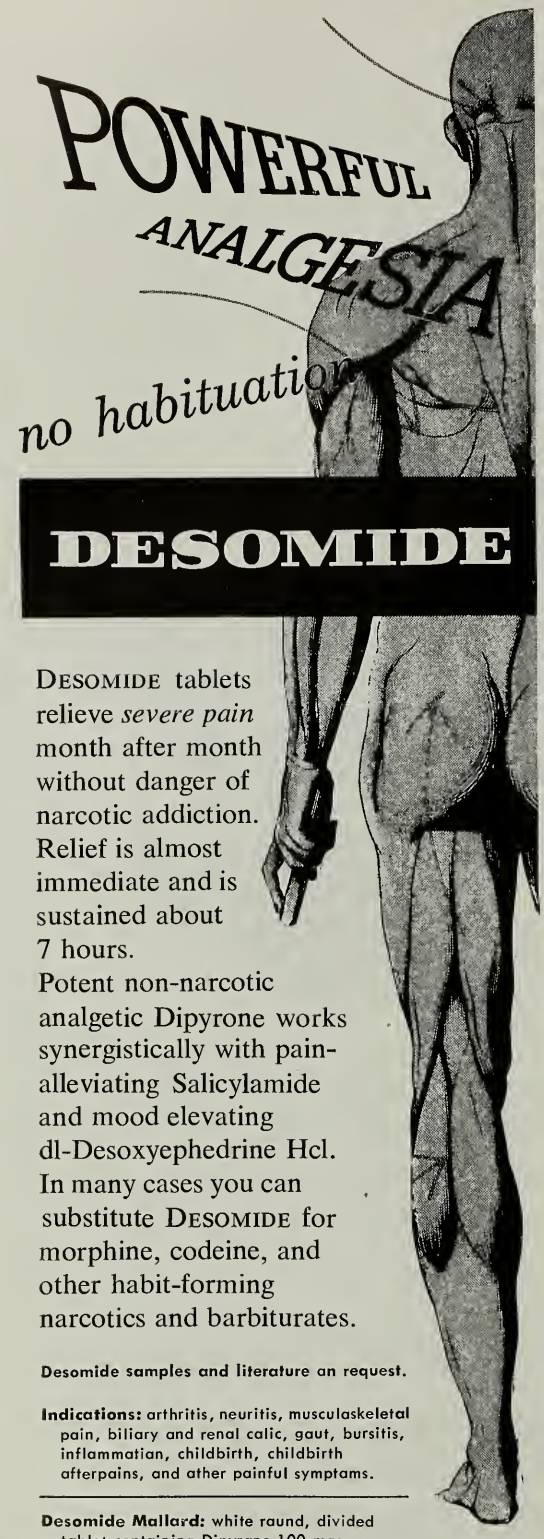

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**a pause for reflection . . .** Operation finished. You sit back and relax. Blockain* anesthesia lasted long enough with one small injection so that you were easily able to proceed from incision to closure without pause for reinjection. **Longer anesthetic duration . . .** You did that accurate reapproximation of skin edges without distortion from freshly introduced anesthetic. And more, Blockain persisted post op.—you had no complaints of uncomfortable splints, dressings or tender tissues. **Rapid onset, too . . .** You recall that the pre-incision wait was avoided. *A case to remember:* A 78-year-old patient, arteriosclerotic, poor liver function with a transcervical fracture of left femur, underwent a *one-hour-and-20-minute operation,* involving internal fixation of the fracture and the placement of a Smith-Petersen nail, with *one injection of Blockain.* Effect of anesthetic: "excellent." Onset of anesthesia: "rapid." Only 60 cc. of Blockain was used. A whiff of nitrous oxide was given at the time of actual hammering, to spare the patient emotional trauma. There were no side effects. **BLOCKAIN,** 30 cc., 0.5% (5 mg./cc.). Write GEORGE A. **Breon** & CO., 1450 Broadway, N. Y. 18 for additional information.

2-PROPOXY DERIVATIVE OF 2-DIETHYLAMINOETHYL 4-AMINOBENZOATE.

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DESOMIDE tablets relieve *severe pain* month after month without danger of narcotic addiction. Relief is almost immediate and is sustained about 7 hours.

Potent non-narcotic analgetic Dipyrone works synergistically with pain-alleviating Salicylamide and mood elevating dl-Desoxyephedrine Hcl. In many cases you can substitute DESOMIDE for morphine, codeine, and other habit-forming narcotics and barbiturates.

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**Indications:** arthritis, neuritis, musculaskeletal pain, biliary and renal calic, gaut, bursitis, inflammatian, childbirth, childbirth afterpains, and ather painful symptams.

**Desomide Mallard:** white raund, divided tablet containing Dipyrane 100 mgs., Salicylamide 100 mgs., dl Desaxyephedrine Hcl 1.5 mgs. AVAILABLE: Battles, 100, 1000.

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## Brill's disease

For many years Brill's disease was considered by many authors to be murine typhus. Some current textbooks still use the two terms synonymously. In 1934, however, Zinsser pointed out the close resemblance of three strains of rickettsiae isolated from cases of Brill's disease to epidemic typhus rather than to murine typhus. He found no evidence that rat fleas were in a factor in transmitting the disease, as is the case in murine typhus. He concluded that Brill's disease is a recrudescence of epidemic typhus which occurs in individuals who had suffered an attack of the disease many years previously while residing in a region of Europe where epidemic typhus had occurred for many centuries.

Brill's disease is not communicable from man to man by contact. Neither the human louse, as in epidemic typhus, nor the rat flea, as in murine typhus, has been incriminated as vectors of the disease. However, Murray et al have clearly shown that human body lice may become typhus infected by experimental feeding on Brill's disease patients during the febrile stage. Therefore, the occurrence of the disease in louse-infected communities might serve as the focus of an outbreak of epidemic typhus. *I. J. Tartakow, M.D. Brill's Disease. New York J. Med. June* 1, 1956.

‹ ›

## A man's world

The menopause appears to be an event unique in the human primate. Although lower animals experience decreased fertility, they are still capable of reproduction at advanced ages and their ovarian follicles still contain ova. Thoroughbred pedigreed mares, for example, have had viable colts while in their early twenties—an advanced age for a horse. It has been suggested, with an admitted lack of reverence, that the menopause is a biologic accident and that women were perhaps not originally destined to live for as many years postmenopausally as modern medical science now permits. *Joseph Rogers, M.D., The Menopause. New England J. Med. Apr.* 12, 1956.

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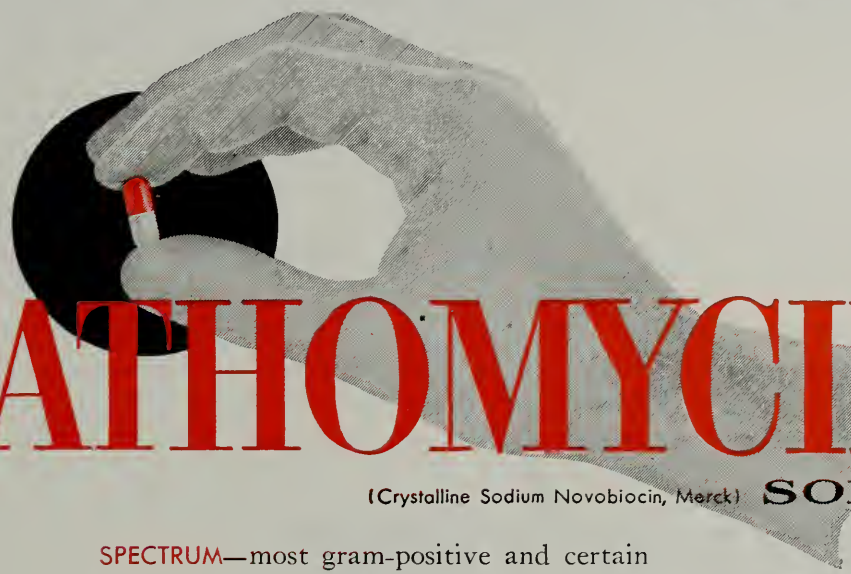
Supplying necessary rehabilitative services emphasizes more than any other instance the combined role of the physician, hospital, and health department in meeting community needs. L. E. Burney, M.D., Calif. Med., Jan., 1956.

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## a unique new antibiotic of major importance

**PROVED EFFECTIVE AGAINST SPECIFIC ORGANISMS**
***(staphylococci and proteus)***

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ACTION—bactericidal in optimum concentration even to resistant strains.

TOXICITY—generally well tolerated. This is more fully discussed in the package insert.

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DOSAGE—four capsules (one gram) initially and then two capsules (500 mg.) twice daily.

SUPPLIED—250 mg. capsules of 'CATHOMYCIN', bottles of 16.

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## Needle biopsy of prostate

The diagnosis of early carcinoma of the prostate continues to be troublesome. Needle biopsy of the suspected nodule may be satisfactory but, as in all needle biopsy procedures, a negative piece of tissue may indicate merely that the needle has missed the nodule. Recent reports on the transrectal route, and our own experiences, indicate that this is a simple, safe, and accurate method of securing a prostatic biopsy. Under general anesthesia the rectal sphincter is dilated and a suitable retractor introduced. The nodule is palpated and a 1 to 2 cm. incision made through the rectal wall down to the prostatic nodule. The nodule is then grasped with a forceps and removed for biopsy. The rectal incision is lightly closed with fine, interrupted gut sutures. If the biopsy proves to be carcinoma, radical prostatectomy can be carried out in several weeks with no unusual operative difficulty. *William F. Melick, M.D. and Joseph J. Naryka, M.D. Recent Advances in Urology. Missouri M. J. June* 1956.

## Carcinoma of lung

As a result of the educational efforts in behalf of carcinoma of the lung, patients are being seen in an earlier phase of this disease, as evidenced by the resectability rate of 32 per cent as compared to 7.5 per cent 10 years ago. The curability of patients operated upon in the early phase is evidenced by the 70 per cent survival rate following therapeutic resections. *Earle B. Kay, M.D. and Frederick S. Cross, M.D. The Present Status of Carcinoma of the Lung. Ohio M. J. March,* 1956.

‹ ›

It would seem to be elementary that, if a patient with an acute lower respiratory infection were ill enough to require hospitalization, an initial diagnostic chest X-ray would be mandatory, and that for pneumonias, additional progress films would be in order. C. Wesley Eisele, M.D., Vergil N. Slee, M.D., and Robert G. Hoffman, Ph.D., Ann. Int. Med., 1956.


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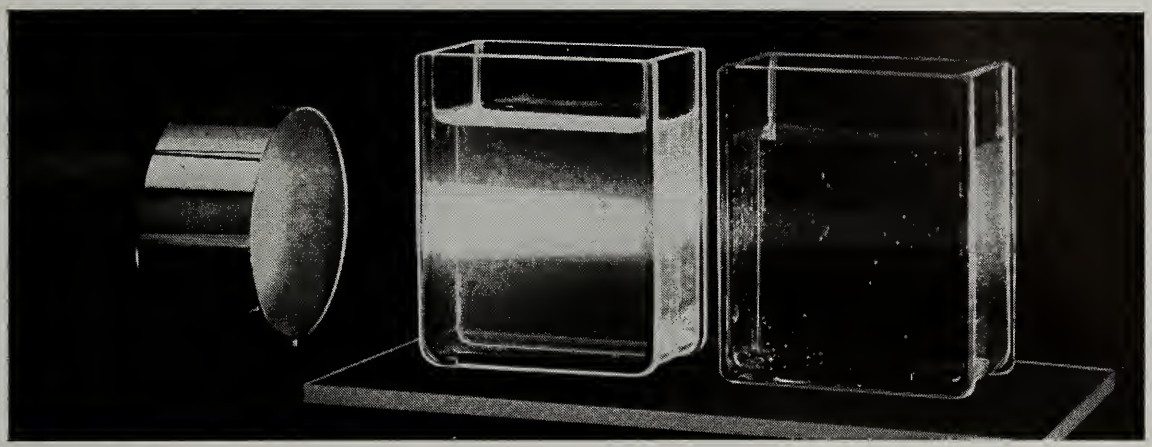
DOSAGE: For obesity, 1 to 2 tablets 30 to 60 minutes before each meal.

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FOR MOOD ELEVATION Rauwidrine provides the needed "lift." Safe for the hypertensive.



# THIRD REPORT



## ANOTHER HIGHLIGHT ON LECITHIN – A NATURAL PHOSPHATIDE

Phosphatides – Clearing Agents of Blood Plasma

Phosphatides have been found in all vegetable and animal cells. There seems little doubt that they are part of the basic structure of protoplasm and also enter into cell metabolism. The most abundantly found phosphatides are the lecithins, whose surface active properties, when combined with proteins and carbohydrates, play an important role as physiologic emulsifiers of fats and oils.[1]

The following considerations highlight the importance of *adequate lecithin plasma concentrations.*

Phosphatides together with cholesterol are found in plasma in combination with proteins and circulate as lipoproteins.[2] The phosphatides in plasma protein are believed to be highly essential for the stability of the complex colloidal system represented by blood plasma.[3] A phosphatide content of 30% or more seems necessary to keep the plasma clear and non-lipemic;[2] lower concentrations will cause the plasma to remain cloudy. (In human plasma lecithin makes up about 80% of the phosphatides present; others are sphingomyelin and cephalin.[2]) A constantly cloudy, lipemic serum can be considered a sign of disturbed fat metabolism, which has been incriminated in the pathogenesis of many serious disturbances. Research on lecithin's potentially useful role in the management of the more complicated forms of deranged lipid and cholesterol metabolism – as in essential hyperlipemia, idiopathic familial hypercholesteremia, xanthomatosis and diabetes – is now being actively conducted. If you are interested in the progress of this research or if you desire to have clinical trial supplies, won't you write to us?

An excellent source of lecithin is Glidden's "RG" Oil-free Soya Lecithin, a highly purified extract containing a minimum of 95% phospholipids. It is packed in a specially designed 8 oz. container to maintain its purity and freshness and is available at your drugstore.

Investigators of lecithin have used quantities from 7.5 to 30 grams daily in divided doses (3 teaspoonfuls equal 7.5 grams).

*Administration:* "RG" Lecithin is presented in palatable granules which may be taken plain, in milk, in orange juice or other citrus juice, or sprinkled on cereal.

Literature available on request.

Bibliography: 1. West, E. S., and Todd, W. R.: Textbook of Biochemistry, New York, The Macmillan Company, 1952, p. 184. • 2. Drill, V. A.: Pharmacology in Medicine, New York, McGraw-Hill Book Company, Inc., 1954, p. 64/6. • 3. Ahrens, E. H., Jr., and Kunkel, H. G.: J. Exper. Med. *90*:409 (Nov. 1) 1949.

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## Fantasy

The study of fantasy is an important tool to the student of human nature. As a rule fantasies are not just idle and stagnating day-dreams that represent unfulfilled wishes. Much more significantly, fantasies, or day-dreams as we are want to call them, represent the stuff out of which ambition and aspirations are fashioned. The fantasies of a 2 year old become the elements of character at age 7 or 8. The fantasies of a 5 year old may contribute importantly to the structure of conscience in later life. A fantasy of an 8 year old may be the impetus for accomplishment in adolescence; and the fantasies in adolescence may well become the life's work in later years. We are aware also that the fantasies of the adult become the very stuff out of which plans, programs, and operations are created. Perhaps you see the enormous value contained in the psychological capacity for fantasy formation. *Maurice E. Linden, M.D. Fate, Feeling, and Fantasy in the Development of Personality. J. Indiana M. A. May* 1956.

## Polio vaccine

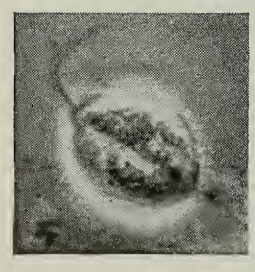
A British improved variant of the Salk vaccine will be used to vaccinate between 250,000 and 500,000 children in Britain in May and June this year. The vaccines have been prepared by two British manufacturers (Glaxco and Burroughs Wellcome) who have been working in co-operation with the Medical Research Council. The vaccines differ from the American preparations in the strain of poliomyelitis virus included. The Type I Mahoney strain used in the preparation of the Salk vaccine is considered unsuitable and has been replaced by a modified Brunhilde strain. Both the British vaccines will contain antibiotics, the final product containing about 50-100 units of penicillin and 200 mg. streptomycin per millimeter. *By the London Post. New England J. Med. March.* 29, 1956.

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Tuberculosis death rates generally are high in the large cities. Cities of 100,000 population and over have a tuberculosis death rate approximately 80 per cent higher than that of the remainder of the country. Robert J. Anderson, M.D., Pub. Health Rep., Feb., 1956.

---


HOW DAVIS TECHNIQUE **EXPLODES** HIDDEN TRICHOMONADS



Too often treatment fails to cure vaginal trichomoniasis because parasites survive and set up new foci of infection.

Now you can overcome this problem with VAGISEC® liquid and jelly, using the Davis technique.† VAGISEC liquid dissolves mucinous materials, penetrates thoroughly, and quickly reaches and explodes the hidden trichomonads.

*Proved highly effective.* VAGISEC liquid (originally "Carlendacide") is the formula developed by Dr. Carl Henry Davis, noted gynecologist and author, and C. G. Grand, research physiologist.[1] Clinical data show better than 90 per cent success with VAGISEC liquid in the treatment of vaginal trichomoniasis.[2]

*Overwhelmingly powerful.* VAGISEC liquid explodes trichomonads within 15 seconds after douche contact![3] One chelating agent and two surface-acting agents, combined in balanced blend, attack the parasite to weaken the cell membrane, to remove waxes and lipids, and to denature the protein. With its cell wall destroyed, the trichomonad imbibes water, swells and explodes.

*The Davis technique.* VAGISEC liquid, as a vaginal scrub, is used in the office therapy. VAGISEC liquid and jelly are prescribed for home use.

*Prevent re-infection.* Many wives become re-infected because husbands harbor trichomonads.[2] To prevent re-infection, prescribe the protection afforded by Schmid high quality condoms. When a rubber is preferred, prescribe the superior RAMSES® prophylactic, transparent and tissue-thin, yet strong. If there is anxiety that rubber might dull sensation, prescribe XXXX (FOUREX)® skins, of natural animal membrane, pre-moistened. At all drug stores.

*References:* 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. *68*:559 (Aug.) 1954. 2. Davis, C. H.: West. J. Surg. *63*:53, (Feb.) 1955. 3. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955.

†Pat. App. for.

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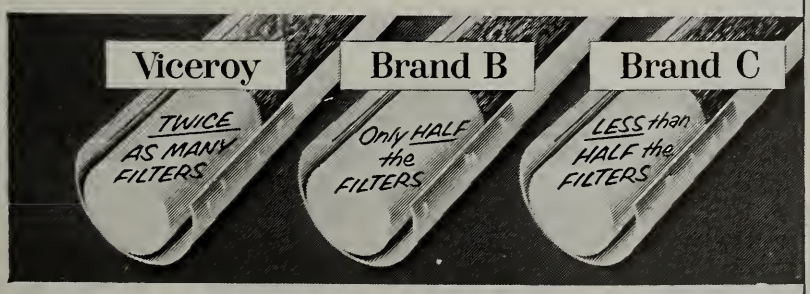



Professional men who have studied the microscopic analysis of the Viceroy filter now know why the Viceroy taste is smoother—never rough. Only Viceroy has 20,000 tiny filters in every tip—twice as many filters as the other two largest-selling filter brands. That is why Viceroys are smoother by far—never, never rough. That is why so many doctors now smoke and recommend Viceroys.

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## Multiple vitamins in P.A.

Despite the ease and excellence of therapy, pernicious anemia too frequently is not treated as well as it deserves. Diagnosis may not be well established or the patient not be well informed, so that therapy is discontinued. The ubiquitous use of folic acid presents a more serious problem. Folic acid will correct the hematological manifestations temporarily but it also hastens neurological manifestations. There has been one report of a group of patients who had developed the neurological complications of pernicious anemia but in whom the anemia had been masked by the use of multivitamin pills containing folic acid. The correct diagnosis was not found until much of the neurological disease had become permanent. This series is now almost triple in size. More recently it has been demonstrated objectively that the oral administration of folic acid decreases serum B12 levels in pernicious anemia patients being treated with parenteral vitamin B12. The administration of folic acid to pernicious anemia patients would seem to be contraindicated, therefore. Vitamin B12 is the only therapy necessary in pernicious anemia and the use of folic acid may only cause complications. *Charles M. Sinn, M.D. Office Management of Problems of Anemia. J. Indiana M.A. May* 1956.

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## Substitute parts

Time was when the word, prosthesis, if used at all, meant a wooden leg or a substitute arm. Now it applies to such things as lucite sphere emplacements in the chest, to plastic blood vessel grafts, and perhaps to the ordinary falsies. A plastic coated glass fabric has been used by Girvin and Merendino of Seattle as a substitute for arteries in animals and recently, in three humans. The fabric is called Teflon, or polytetrafluorethylene and is said to be slick, nonwettable, of great tensile strength, and costs only $15 a yard. The most dramatic use was to replace a 17 cm. length of aorta in a 77 year old man. The duration of its life is still uncertain. *Guillermo Osler, M.D. Topics of Current Medical Interest. Arizona Med. March* 1956.

‹ ›

If any men seeks for greatness, let him forget greatness and ask for truth, and he will find both.

— Horace Mann




Typical Sanka Booth At Medical Conventions All Over The Country

# Your verdict was "DELICIOUS!"

## *and your patients will agree*

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And just as a reminder—why not tell your caffein-sensitive patients about Instant Sanka Coffee? They can drink as much Instant Sanka as they want without being bothered by sleeplessness or jitters due to caffein.

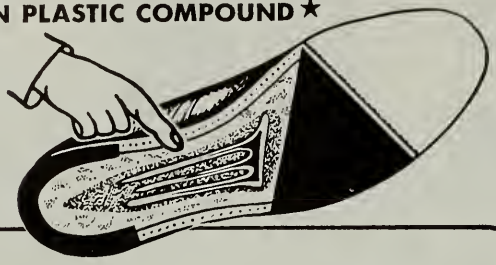
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For the modification of measles and the prevention or attenuation of infectious hepatitis and poliomyelitis.

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## Hepatitis epidemic

During the fall and winter of 1953-54, 100 eases of infectious hepatitis in adult mental patients were observed and treated at the Elgin (Ill.) State Hospital.

The highest ineidenee of eases, 98 out of 100, appeared in eottages housing the more deteriorated and untidy patients; 62 were diseovered in a residenee for severely regressed women possessing poor personal hygienie habits and living under grossly overerowded eonditions.

No uniform pattern of attaek could be determined sueh as appearance of groups of eases at periodie intervals.

The laek of ineidenee among hospital employees earing for the patients was aseribed to high standards of personal hygiene and sanitation among the personnel.

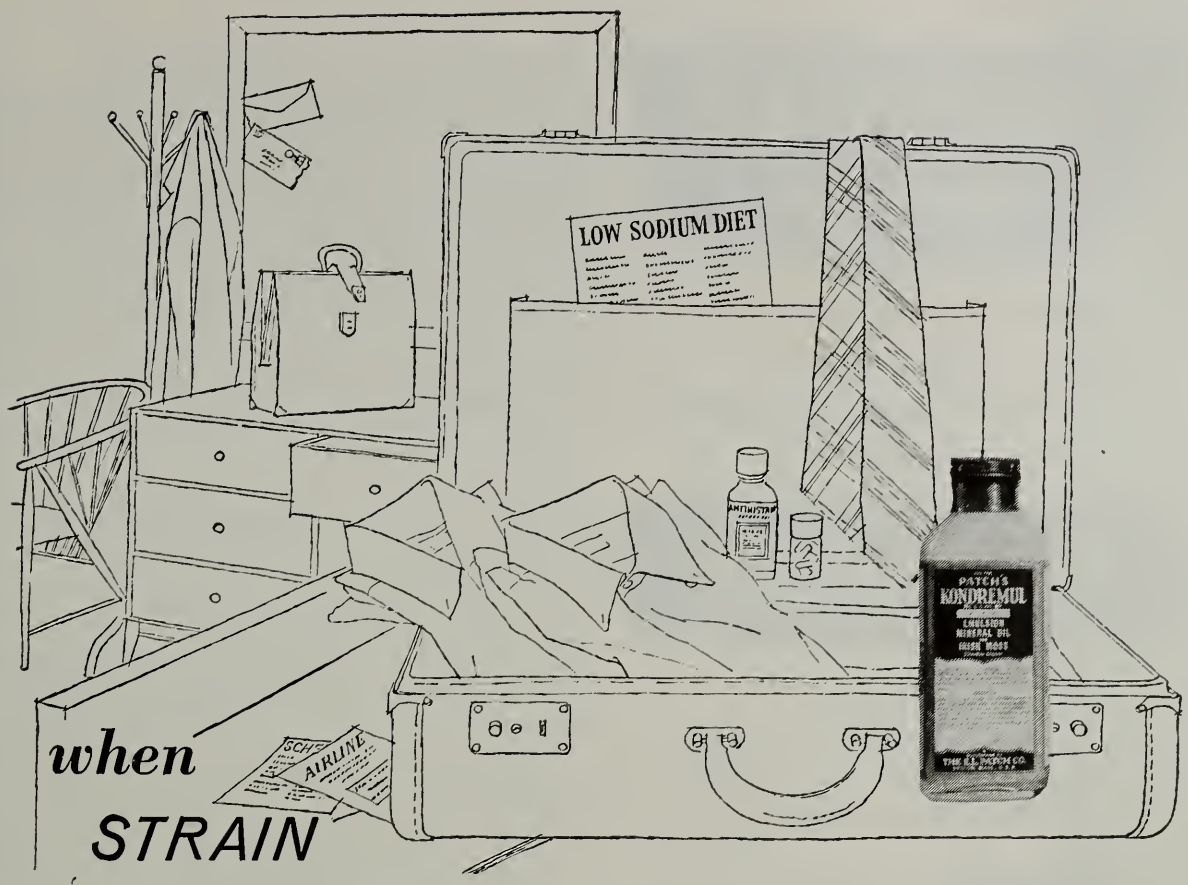
The vehicle of eontamination or mode of transmission was never ascertained, although exhaustive and eontinued investigation excluded, we believe, the water and food supplies and the sewage disposal system as the souree. The fecal-oral route is suspeeted, but the area of spread also points to person-to-person contact with a earrier as a likely mode of transmission. *Otto L. Bettag, M.D., et al. Infectious Hepatitis Epidemic in a Mental Hospital. Pub. Health Rep. April* 1956.

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Despite a gratifying decline in the death rate, the tubereulosis problem in this country will not approach aeeeptable solution until the morbidity rate demonstrates a corresponding deeline. Over the last five years, deaths from tuberculosis have deelined between 15 and 20 per eent each year. The morbidity rate, however, has declined only three to four per eent per year over the same period of time. At this rate, more than a quarter century will be required to equal the same per cent reduction in morbidity that has been aehieved in mortality in the past five years alone. An. Rep. Div. Special Health Services, U.S. Department of Health, Edueation, and Welfare, Washington, D.C. (1954-1955)

‹ ›

A little experience often upsets a lot of theory.
— Cadman




*when* STRAIN *must be avoided*

*...as in* HYPERTENSION

# KONDREMUL®

(COLLOIDAL EMULSION OF MINERAL OIL AND IRISH MOSS)

## FOR CHRONIC CONSTIPATION

*when the "going" is rough*

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(PLAIN)

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**KONDREMUL WITH CASCARA**—0.66 Gm. *nonbitter* Ext. Cascara/tbsp.

**KONDREMUL WITH PHENOLPHTHALEIN**—0.13 Gm. phenolphthalein/tbsp.

KONDREMUL belongs in the picture whenever *strain-free elimination* is a "must." The softening and infiltrating action of KONDREMUL results in a soft, well-formed, easily passed stool . . . with no irritation, griping, or tenesmus. KONDREMUL is an outstanding mineral oil emulsion because of its high stability and the extremely small, uniform size of its oil globules, each held firmly in an envelope of Irish moss. No unpleasant leakage.

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## Cold leads to arteriosclerosis

When rats are exposed to a cold environment (1°-3° C.) for long periods many metabolic changes take place. Increased heat production is necessary to maintain body temperature, and this higher expenditure of energy results in a large increase in oxygen consumption and in food intake. Changes in carbohydrate, fat, and nitrogen metabolism and in adrenal, thyroid, and pituitary function are observed. No doubt most of these changes are adaptive phenomena associated with the augmented ability of the rat to survive under adverse environmental conditions. Over a long period of time, however, it might be anticipated that adverse effects on certain tissues might occur. In spite of the fact that after 12-24 months of exposure to cold the gross appearance of the visceral organs of the rat is not much altered, the weights of many of the viscera are increased and histological evidence of structural changes is present. Deposition of fat in the intima and media of the coronary arteries was observed by one of us several years ago and referred to in discussion. *E. A. Sellers, M.D. and Rosemary W. You, M.D. Deposition of Fat in Coronary Arteries After Exposure to Cold. British M. J. April* 14, 1956.

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## In want of a name

We find a . . . poignant example of the restrictive aspects of idiom in the emotional reactions to old age incorporated in various languages. The meaning of the French veillard, the Spanish viejo, and the German alte—all terms implying respect and affection—is certainly inadequately represented by the English old man, which implies the decrepit rather than the venerable. Do we have such a poor opinion of old age because we have no simple honorific words for it? Or do we have no words for this status because we do not honor it? Probably a bit of both. We are faced here with a vicious circle of attitudes and words, the breaking of which is essential to a successful program of social geriatrics. *Garrett Hordin, M.D. Scient. Monthly. March* 1956.

‹ ›

A man has to live with himself, and he should see to it that he always has good company.

—*Charles Evans Hughes*

plateau therapy*...

# for hay fever and other allergies




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## Tuberculosis—1955. Is hospital care necessary?

*By Ralph E. Dwork, M.D., Ohio State Med. J., May, 1955.*

The rapidly changing pattern of treatment of tuberculosis, especially since the announcement of isoniazid early in 1952, has made it increasingly important to "keep up" in this field. Questions have arisen regarding the need for hospital care, the duration of such care, and the intelligent handling of antimocrobial drug therapy. For these reasons it has seemed desirable for the Ohio Department of Health to present the best informed opinion available at this time.

How have drugs influenced the duration of hospital care? Drug therapy has shortened both the average duration of hospital care and duration of bed rest for patients with early active disease. It has lengthened the period of hospital care for a significantly large group of patients, who would otherwise die early, but now are kept alive as chronic cases for a long time, with drug therapy.

Is hospital care necessary for all active cases or will home treatment suffice for many such patients? If there are insufficient beds available, home treatment using antituberculous drugs obviously is the next best procedure. Rather dramatic early improvement is often seen in active TB treated at home with antituberculous drugs, but some such cases suffer spread of disease and may lose their chances for recovery.

Recently, James J. Waring, M.D., a former president of the National Tuberculosis Association, acknowledging the disadvantages of TB hospital care, such as expense, separation from family, and restrictions of hospital living, pointed out the serious deficiencies of home care in tuberculosis. Members of the family and the public frequently are exposed unnecessarily to tubercle bacilli. The patient at home seldom obtains an understanding of his disease and the attitude toward its long term treatment which will lead him to protect his health long afer active treatment has been stopped. This education which comes from the staff and other patients in the TB hospital is usually not accomplished when the patient is treated at home. Systematic rest at home is difficult to attain without supervision. In the hospital, rest is a prime consideration.

(*Continued on page 72*)


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**Percentages of Recommended Daily Dietary Allowances* for Children Provided by Enriched Bread—6 and 8 slices**

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| | 6 slices | 8 slices | 6 slices | 8 slices |
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| Niacin | 38 | 50 | 30 | 40 |
| Riboflavin | 18 | 23 | 14 | 19 |
| Thiamine | 41 | 55 | 33 | 44 |
| Calcium | 12 | 16 | 12 | 16 |
| Iron | 41 | 55 | 33 | 44 |
| Calories | 24 | 32 | 19 | 25 |

*National Research Council's recommended daily dietary allowances (1953):
Children, 4 to 6 years of age; weight, 40 lbs.; height, 43 inches.
Children, 7 to 9 years of age; weight, 59 lbs.; height, 51 inches.

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### TUBERCULOSIS — 1955 (Continued)

The early weeks of drug therapy often are complicated by symptoms requiring changes in regimen, insistence on regular administration, and moral support by the staff. At home the drugs prescribed may be omitted or taken irregularly with the result that early drug resistance develops. Toxicities of drugs in use and complications may go unrecognized for long periods when the patient is at home. In the hospital such incidents are handled safely and promptly. The increased importance of surgery in tuberculosis makes it essential that the strategic moment for intervention not be missed. Recent experience indicates that many patients treated at home are not being considered for surgery at any time. The technical facilities of laboratory and X-ray often provide crucial information determining the course of therapy. Such aids often are inadequately provided in home treatment but the hospital patient usually has access to the necessary services. Altogether, it is seen that while home treatment of tuberculosis may, at times,

(*Continued on page* 74)


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be successful, there are many hazards associated with it.

After viewing the problem of rest and exercise, the Committee on Therapy of the American Trudeau Society recently said, "The Committee on Therapy points out again that, from the facts now available, there is no evidence to support a reduction in the amount of rest therapy from that of past practices except as it may be justified by an earlier attainment of an inactive status of the disease . . . The patient should be hospitalized, if at all possible, throughout the infectious stage of his disease. In addition to the benefits of hospitalization to the patient, this is sound public health practice to prevent the spread of tuberculosis . . . The total period of disability, though greatly shortened, on the average, with antimicrobial therapy, must still be estimated at a minimum of one year, even in mild cases which respond favorably to treatment."

When there were insufficient beds for the care of tuberculosis patients, there may have been some justification for individual cases remaining at home. Now that beds are available, a special obligation falls on the health departments and practicing physicians to see that active cases and potentially infectious cases are in hospital beds.

Public health officers and practicing physicians are in a strong position in insisting that every case of active tuberculosis have a period of treatment in a tuberculosis hospital. This period will be variable in length but must continue until the patient is not a hazard to his associates and until all therapeutic factors have been utilized to the patient's maximum benefit. The Ohio Department of Health recommends that all health departments and practicing physicians take a firm stand to the end that the process of tuberculosis control be accelerated to its maximum.

‹ ›

No theory of the universe can be satisfactory which does not adequately account for the phenomena of life, especially in that richest form which finds expression in human personality.

*—B. H. Streeter*

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**Vol. 110, No. 2**

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**Medical Arts Building**
**Monmouth, Illinois**

Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Return undeliverable copies under form 3579 to 1501 W. Washington Road, Mendota, Illinois.

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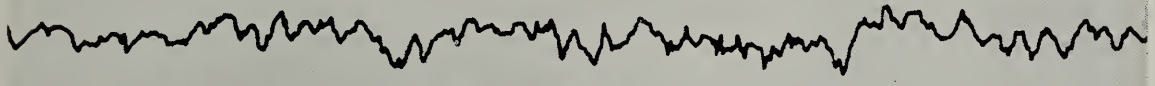
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# The Month in Washington



Washington, D. C. — If medical research doesn't move ahead in the current fiscal year (ending June 30, 1957), it won't be the fault of Congress. The seven research organizations that make up the National Institutes of Health have far more money than they have ever had, and probably much more than their directors even dared hope for last winter at the start of hearings on their budgets. Every one of the research institutes received a substantial increase over last year, and the funds of five of them were almost doubled.

The Institutes have a total of $170.4 million to spend before next July 1. This is about 80% more than they had last year. In discussing the appropriations bill on the Senate floor, Senator Lester Hill (D., Ala.) said the bulk of the money will go for grants to non-federal institutions-hospitals, medical schools, clinics and state and local organizations engaged in research.

A breakdown by disease categories shows the following picture:

For cancer research, $48.4 million, in contrast to $24.8 million for the previous year. This year's total is $16 million more than the administration asked when budget requests were sent to Congress in January.

For mental health work, $35.1 million, in contrast to last year's $18 million. This is $13.4 million more than had been requested originally.

For heart disease research, $33.3 million, compared with $18.7 million last year and $22.1 million originally requested.

For work on arthritis and metabolic diseases, $15.8 million, or $5.1 million more than last year and $2.5 million more than Congress was asked for.

For research in neurology and blindness, $18.6 million, compared with $9.8 million last year and $12.1 million originally requested.

For work on allergies and infectious diseases, $13.2 million, compared with $7.5 million last year and $9.7 requested.

For dental research, $6. million. While this is small compared with money voted for other U. S. research institutes, it is almost triple the $2.1 million spent last year. The huge increase is the result of a sustained campaign by the American Dental Association.

Senator Hill and Rep. John E. Fogarty (D., R. I.) led the fight in Congress for the record-breaking research appropriations. Under the latter's chairmanship, a House appropriations subcommittee boosted the total for the seven institutes to about $124 million, a figure that was accepted both by the full Appropriations Committee and the House.

In addition to heading the Senate appropriations subcommittee that handled this funds bill, Senator Hill also is chairman of the Labor and Welfare Committee and extremely active in health legislation. His subcommittee pulled up the totals to the $170 million. After the Senate-House conference committee disagreed on the spending, Rep. Fogarty carried the fight to the floor, where he persuaded the House to accept all of the higher Senate figures.

Other federal health programs, mainly concerned with disease control and hospital construction, also fared well with the Congress. The Hill-Burton program, for construction grants

(*Continued on page* 34)

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**WASHINGTON (Continued)**

to hospitals, has $125 million for the current year, or $14 million more than last year. For vocational rehabilitation grants, the figure is $41.5 million, a $2.7 million increase; for general public health assistance to states, it is $18.-16 million, a $600,000 increase; for Indian health work, it is $38 million, a $3.3 million increase.

**NOTES**

With Salk vaccine being released in ever expanding volume, the Public Health Service is urging states and communities to increase the priority age to 20 and to use up supplies as fast as received. Said Secretary Folsom: "I urge parents, physicians, and health officials to cooperate in making the maximum use of the increasing supply as soon as it becomes available. . ."

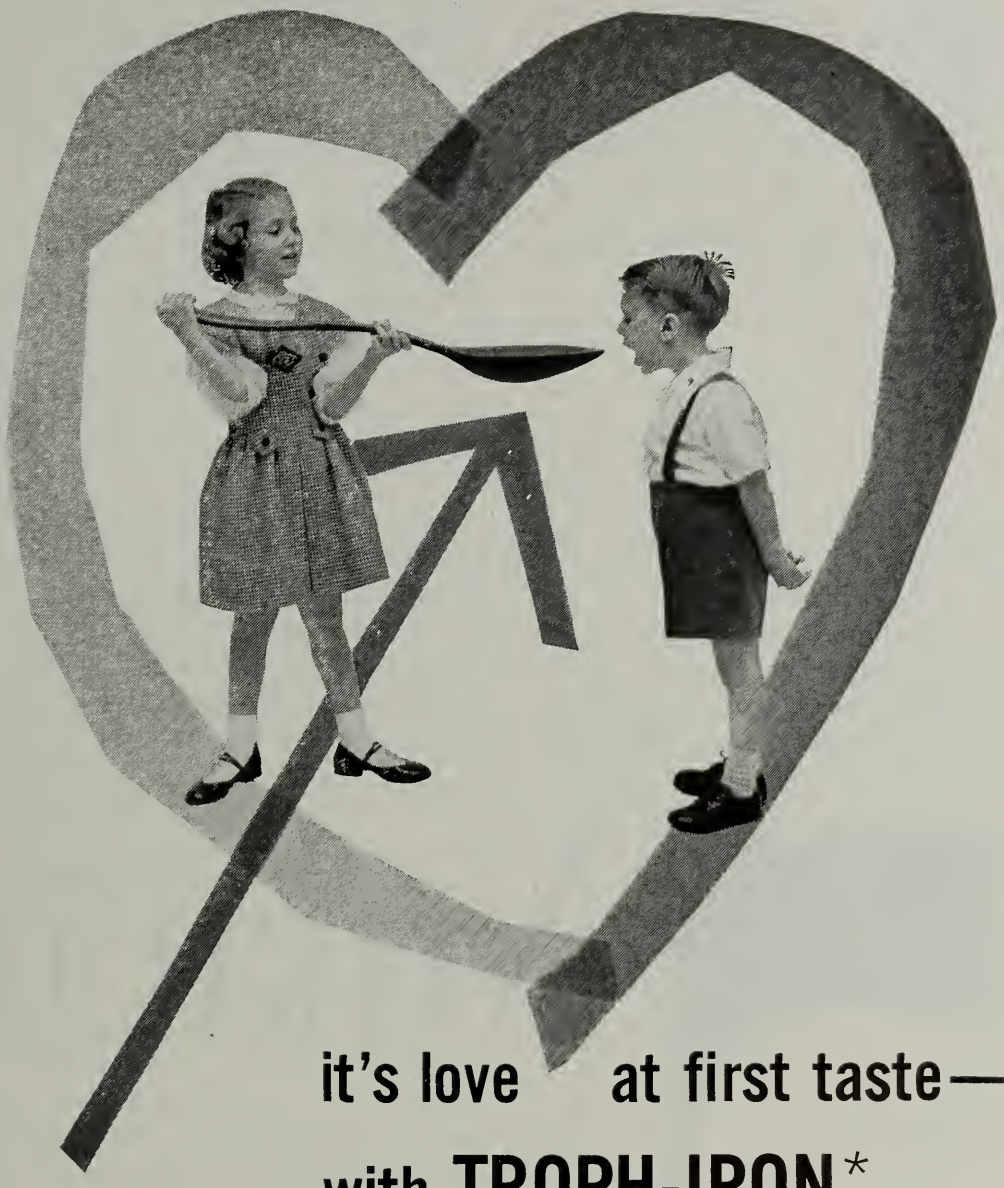
Civil Aeronautics Administration, believing the time has come to review procedures in pilot medical examinations, has hired a private organization to conduct a thorough investigation and make recommendations. Two questions: Should lower standards be allowed for older, experienced pilots? Should crew members and ground crewmen, as well as pilots, be examined periodically?

Less than three months after his third appointment to a four-year term as Surgeon General of U. S. Public Health Service, Dr. Leonard Scheele resigned to take a post in the pharmacentical industry so he could "provide more properly" for his family.

Although no new legislation was enacted in that field, witnesses at a long series of hearings on civil defense were pretty much in agreement that the job can't be done properly unless more authority is voted to the Federal Civil Defense Organization.

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In general the chronic degenerative diseases, neurological diseases, sensory disorders, mental disease and severe injuries due to accidents make up the major health problems for the nation as a whole. All age groups are represented among those afflicted by these conditions whose one common characteristic is prolonged duration. Care of the "long-term patient" is, in fact, the chief health problem for the physician and the patient's family, for the community, and for the nation as a whole. L. E. Burney, M.D., Calif. Med., Jan., 1956.



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## The value of seat belts

We have collected a total of 62 crashes with belts to date, with only two fatalities. These were in open cars, a convertible and a sports car, both of which overturned. While these two fatalities might have been avoided if the victims had been free to be thrown from the car, careful studies indicate that one's chances are better by two to one, if one stays in the automobile. Thus these fatalities indicate, not that belts are dangerous, but that open cars are dangerous. In these 62 crashes, three other persons received severe injuries, one to the head and one to the chest. These two would have been prevented by the use of shoulder straps. In the 57 remaining cases, the injuries were all minor, even in some crashes which the investigating authorities rated as "sure fatals." These cases give clear cut evidence that our traffic deaths and injuries can be reduced sharply by the routine use of devices to hold the motorist in his seat. At the moment, the familiar seat belt is the most accessible device. Sooner or later, newer and better devices will come into being, if the motoring public insists upon safety in its motor cars. There has been considerable controversy among the experts and the publicity men as to what per cent of the present deaths and injuries the seat belt would save. The suggested percentages run between 25 and 90. *Horace E. Campbell, M.D. Twenty-One More Auto Crashes with Seat Belts. Rocky Mountain M. J. April* 1956.

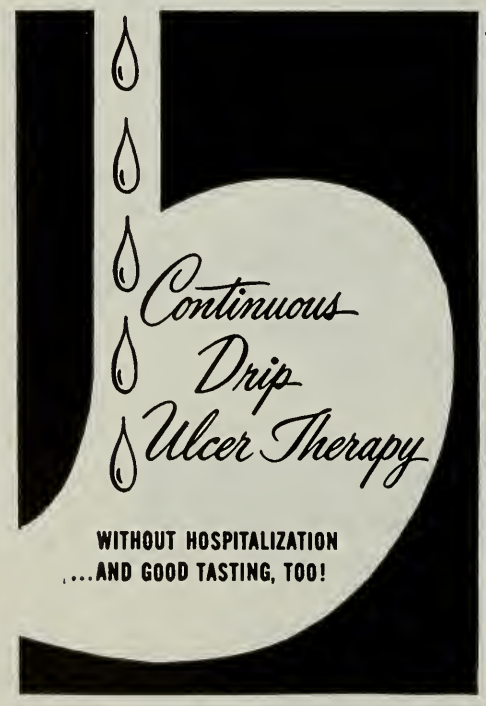
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## Ike's heart

"So what," said Uncle Wilfred. "When these cardiologists voted 141 to 93 in favor of the idea that President Eisenhower is medically fit for a second term, they only proved that about three out of five heart specialists are Republicans." *Editorial. GP April* 1956.

‹ ›

Chemotherapy has more certain and sustained effects on tuberculosis than rest treatment alone. Resolution and fibrosis are more rapid and complete, but the healing processes are substantially the same as those observed in the natural course. Necrosis of tissue may be averted or retarded. J. Burns Amberson, M.D., Ann. Int. Med., Dec., 1955.


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# Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

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*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

The
ILLINOIS
Medical Journal




**Official Journal of The Illinois State Medical Society**

AUGUST, 1956
VOL. 110 NO. 2

# Cultured Calf Bone: A New Bone Grafting Material

**Irvin Clayton, M.D., Chicago**

WITH improvement in grafting techniques and methods of storing bone, countless patients have benefited from bone grafts. Prior to the development of adequate storage methods the main sources of bone for grafting were: the individual himself (autogenous grafts) and bone from another person (homogenous grafts)[3]. However, in some instances it was undesirable or impossible to obtain bone from the individual or a donor. In an effort to solve this problem and provide an unlimited source, Orell[7] made numerous studies and in 1937 presented his work with beef bone which he called "os purum" and "os novum". In 1947 the first successful storage of bone for any length of time was introduced, using a deep freeze[13]. Shortly thereafter, the merthiolate bank also was found to be satisfactory.[9]

Since then numerous comparisons have been made between cancellous and cortical autogenous, homogenous and heterogenous bone stored by different methods in an effort to determine the material most readily incorporated and the most suitable method of storing this material.[1,2,3,5,8,11,12,14,15] These studies have shown cancellous bone to be incorporated more quickly than dense cortical bone. Fresh autogenous and homogenous bones are superior to the same bone stored in merthiolate or deep-freeze banks. Recent studies have shown frozen heterogenous bone to be equal to frozen homogenous bone as a bone grafting material.[4,5,10,12]

Many hospitals are unable to set up bone banks and keep them adequately stocked. It is almost impossible in smaller hospitals and is occasionally difficult in as large a hospital as Wesley Memorial Hospital, Chicago (570 beds). Although proved to be successful, the preparation of beef bone by Orell's method is so difficult and long drawn out that the disadvantages outweigh the advantages.

Several years ago, in an effort to make bone available to hospitals without banks, Dr. E. J. Tucker of Houston, Texas, began studies on simpler methods of bone storage so that it might be shipped from one place to another without special handling or equipment.[11,12] Among other methods tried was the storage of human bone in human plasma. After the bone was stored in plasma at 40 degrees F. for several months, Dr. Tucker noted certain gross and microscopic changes that do not occur in bone stored in any other way. Calf and canine bone, when stored in plasma of their own species also undergoes

*From the Department of Orthopedic Surgery, Northwestern University, Chicago.*

*Read before combined meeting of Metropolitan Chicago Chapter of American College of Surgeons and Chicago Orthopaedic Society, Chicago, Sept. 22, 1955.*

these changes, which do not occur unless the bone is stored in the plasma of its own species. Because of difficulty in obtaining large quantities of human bone, Dr. Tucker turned to calf bone because of its almost unlimited supply and the fact that previous investigators have reported its use in numerous cases with success equal to that of frozen homogenous bone with no apparent reactions.[4,5,7,10,12]

It was found that the density of cortical bone and the number of osteocytes per field in a 300 pound calf are about the same as that of a normal adult human.[12] The animal from which the bone is to be obtained is tested for tuberculosis and brucellosis and passed by government inspectors. Following a surgical prep, the leg to be used is removed from the animal and taken to a sterile operating room where the bone is removed under rigorous aseptic technique. To prevent destruction of cells by excessive heat from electric saws, a hand saw is used in cutting the bone. All of the bone for implants is placed in one large container and covered with a solution of 20% bovine plasma in balanced saline. One million units of penicillin, with two grams of streptomycin, are added to each liter of solution. The container is sealed with a sterile cap and placed in an ordinary refrigerator at 40 degrees F.

After the bone has been in storage for 14 days, a portion of the solution is removed for testing. Thus the bone is cultured with anaerobic and aerobic media and guinea pig innoculation. When all cultures are proved negative, the bone is removed from the large container under strict asepsis and placed in individual containers with fresh plasma solution. A final culture is then made of each container with thioglycollate broth medium.

Dr. Tucker has chosen the name "cultured calf bone" for bone prepared by this technique.[12] Because of his experience, he has developed a theory with regard to cultured calf bone which I shall present, along with the experimental and clinical evidence supporting this theory. Knowing that bone normally has a low metabolic rate, and working on the premise that bone remains alive for a short time after removal from its host,[6,14] Dr. Tucker felt the best way to prolong viability was to place the bone in its normal nutrient medium and lower the metabolic rate still further by refrigeration.[12] Theoretically storing the bone for a minimum of five months before use, accomplishes two things: Bone, following its inherent ability, begins the process of repair along its cut edges as demonstrated by an extensive collagenous formation; and calf bone during this time loses its species specificity which accounts for its lack of foreign body reaction when used as a heterogenous graft. The fact that the process of repair has already been initiated prior to grafting, plus the lack of foreign body reaction, probably explains the early incorporation of cultured calf bone.

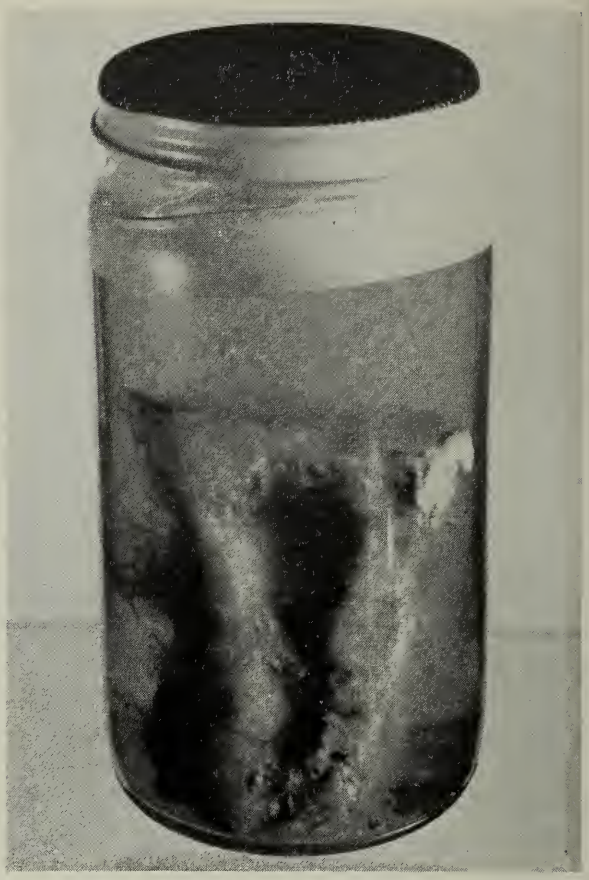


**Figure 1. Cortical calf bone stored in bovine plasma at 40 degrees F. for five months demonstrating the gross proliferation from the cut surface of the bone.**

The gross proliferation of collagen fibers (Figure 1) can be seen from the cut edge of a piece of cortical calf bone stored in bovine plasma at 40 degrees F. for five months. A microscopic section (Figure 2) of cortical calf bone denuded of its periosteum and stored in bovine plasma at 40 degrees F. for six months also shows the fibrous proliferation from the



Figure 2. Photomicrograph (X 125) of a section of cortical calf bone denuded of its periosteum and stored in bovine plasma for five months. Note the large number of osteocytes present, the fibrous proliferation from the surface of the bone, and the loose structure of the bone itself.

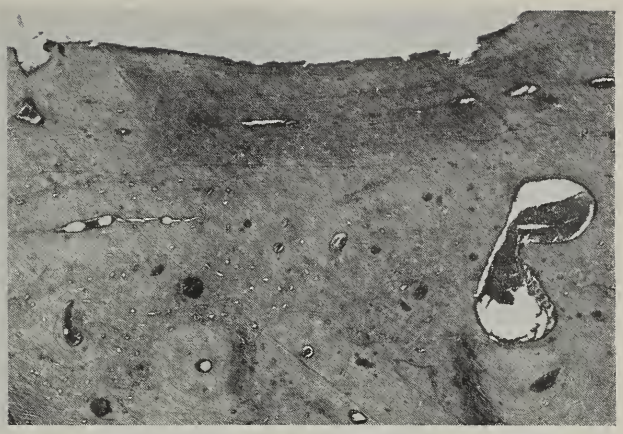


Figure 3. Photomicrograph (X 125) of a section of calf bone after being stored at minus 10 degrees F. for six months. This section came from the same bone as Figure 2 and shows relatively few bone cells, no proliferations from the surface of the bone, and a compact bone structure.

surface of the bone. In addition, this section illustrates the large number of osteocytes present and a loose structure of the compact bone itself. Regardless of the discussion pro and con on the viability of these cells, they are indisputably present.

Microscopic section (Figure 3) from a piece of cortical bone taken from the same calf as shown in Figure 2, but stored at minus 10 degrees F. for six months shows relatively few osteocytes, no fibrous proliferation, and a much more compact bone structure.

The extensive collagenous proliferation demonstrated in bone stored in plasma at 40 degrees F. for several months is believed to be the ground substance or matrix of early bone formation in which apatite crystals are normally precipitated. Loose structure of the bone and the collagenous proliferation following storage in bovine plasma makes it unnecessary for the recipient to mobilize large numbers of osteoclasts before incorporation of the graft can begin, which would explain the rapid union of this type of bone graft.

To substantiate this, an additional experiment was carried out. Since it is not desirable to take material for section from patients following the use of calf bone surgically, it was decided to use human bone stored in human plasma at 40 degrees F. for 5½ and 15½ months as onlay grafts in the foreleg of a calf. In the opposite leg of the same animal, pieces of frozen human bone and calf autogenous bone were used as control grafts. Six weeks postoperatively, the incisions were reopened. There was early union of both sections of human bone which had been stored in plasma. Microscopic section (Figure 4) taken through the region of these grafts showed union and no foreign body reaction. In the opposite leg, there was no union of the frozen human bone and union of the calf's autogenous bone. Microscopic section (Figure 5) of the frozen human bone showed no union and there was a marked foreign body reaction. The autogenous control showed union both grossly and microscopically (Figure 6) with no foreign body reaction.

Cultured calf bone, like all bone grafts, must

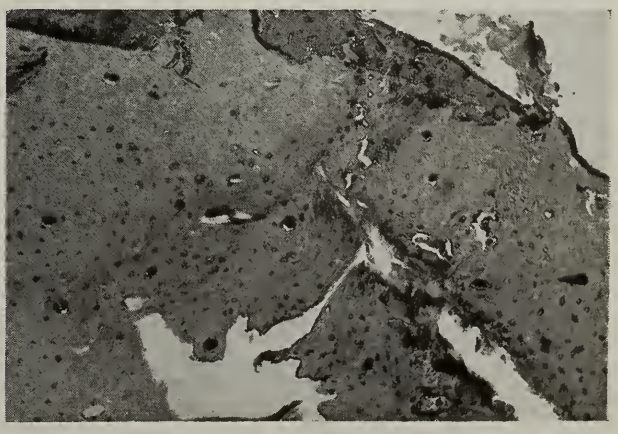


Figure 4. Photomicrograph (X 120) through the region of human bone grafted on calf bone. The human bone is on the upper right showing union of the graft with no foreign body reaction.



**Figure 5. Photomicrograph (X 125) through onlay graft of frozen human on calf bone showing nonunion with marked foreign body reaction.**



**Figure 6. Photomicrograph (X 230) showing early union of autogenous calf bone onlay graft with no foreign body reaction.**

be used with the same precautions attending any grafting technique. To date, cultured calf bone has been used in 61 cases: 36 lumbosacral fusions, nine nonunions (four in the tibia, four in the humerus, and one in the radius and ulna), two spinal fusions for tuberculosis, two posterior bone blocks of the os calscis, two cranial defects, three osteotomies, two acute fractures of the distal third of the tibia, one spinal fusion for scoliosis, one shoulder fusion, one bone block of the hand for an opponens paralysis, one unicameral bone cyst following pathologic fracture, and one congenital deformity of the tibia. This series does not include the large amount of ground calf bone used by dentists for mandibular cysts and filling of sockets following teeth extractions. No infections or reactions have been reported in any of these cases except one. This was the transplant of a fetal calf epiphysis to a congenitally deformed tibia in an infant. The incision drained a serum-like fluid for six or eight weeks and then healed spontaneously. The transplant now shows healing. No cultures were taken and it is not known whether infection or reaction was responsible. The remainder of the cases, except those too recent to report, have gone on to satisfactory results.

This study has shown that we can always be assured of having bank bone available as calf bone is in unlimited supply. Also, using Dr. Tucker's method of storage, the bone may be shipped from one place to another with little or no trouble, thus making it available to hospitals unable to maintain a bone bank. Equally important is the experimental evidence that this bone remains viable for long periods. The cost is expected to be less than a pint of blood.

Clinically, the results thus far have been at least equal to autogenous grafts. Whether cultured calf bone is superior to autogenous bone cannot be answered from such a small series of cases. Only through increased clinical use can this question be answered.

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# Early Progress of the Central Artery Bank of the Chicago Heart Association

*Frank Milloy, Jr., M.D., and **Egbert H. Fell, M.D., Chicago

THE recent increase in the use of arterial homografts in vascular surgery has made it desirable to establish a central facility for the purpose of obtaining and processing as many vessels as possible for use in the Chicago area. The ample availability of proper autopsy material from the pathology departments of the Cook County Hospital was mentioned by Dr. Lester Dragstedt to Dr. Hans Popper about two years ago, and as a result of this conversation a start was made towards organizing an artery bank. The experiences obtained in the formation of such a bank may be of interest to others.

The interest of the Chicago Heart Association was enlisted, and through the Cardiovascular Surgery Committee of that organization, under the Chairmanship of Dr. Geza de Takats, funds were made available and a program outlined. A pilot study was instituted at Northwestern University Medical School by Doctors Bernhard and Laufman[1] and their experiences along with those of Dr. O. Julian and Dr. W. Grove at the University of Illinois, Dr. W. Adams at the University of Chicago and Dr. W. Potts at Children's Memorial Hospital provided a background of information from which to draw.

A resident in Pathology at Cook County Hospital was retained by the Heart Association for the purpose of obtaining vessels, and space was donated by the Hektoen Institute for Medical Research. The first vessels were taken under full sterile precautions with the donor surgically draped and the prospectors gowned and gloved. Although this method provided sterile vessels, it required around the clock availability of at least two people so that the vessels could be obtained within six hours of death. It was also inconvenient for the pathologist in that it held up the remainder of the autopsy three to four hours.

For these reasons the use of Betapropriolactone was introduced as a sterilizing agent[4] for vessels obtained under the conditions of a routine autopsy. About 30 vessels were obtained and sterilized with this substance, and preserved either in a frozen state at −70° C. or in a balanced electrolyte solution at 4° C. Both of these methods of preservation have disadvantages. Once a vessel is quick frozen to −70° C. it must be kept at that temperature until used. This makes it very difficult to send vessels to different hospitals with the understanding that they may be returned if not used. Vessels kept at icebox temperatures, about 4° C., are not good after four or five weeks because of degeneration of the elastic tissue.

In July of 1955 lyophilization equipment was set up,[2,3] and the services of a full time technician obtained. The acquisition of an explosion proof hood made it possible to introduce the use of ethylene oxide as a second method of sterilization.

PRESENT PROCEDURE: Vessels are obtained from subjects under the age of 40 having no disease of the aorta. They should also be free of infectious diseases such as infectious hepatitis, the collagen diseases, and pus. Tumor tissue should not be in the area of the vessel. The vessels should be obtained within six hours of death, or if this is not possible, and the body has been promptly refrigerated following death, within 24 hours. The vessels are taken during the routine autopsy. Care is taken not to injure the vessels and to leave all branch arteries long so that they may be ligated easily just prior to use. The carotid, subclavian, and iliac arteries are divided as far distal as possible and tagged for the convenience of the embalmer. Blood for serologic examination is likewise obtained. The aorta is carefully cleaned of all extraneous tissue in a flat dish containing physiologic

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**Attending Surgeon, Presbyterian and Cook County Hospitals; Clinical Professor of Surgery, University of Illinois College of Medicine; Director of the Artery Bank.



**Figure 1. The vessel is freed from all loose tissue. The segmental branches remain long and untied. Placing the aorta in sterile normal salt solution aids in removing the extraneous tissue.**



**Figure 2. The sterile vessel is rapidly frozen in −70°C. dry ice acetone bath.**

saline (Figure 1) and usually divided into two segments at the level of the celiac axis. After cleaning, the segments are sterilized in one of two ways. After two hours incubation in a properly diluted solution of Beta Propriolactone, the vessel is rinsed in a buffer solution and may be considered sterile. Or, the vessel may be placed in ethylene oxide for one-half hour for sterilization. At the present time both of these methods are thought to be highly efficient for sterilization and cause a minimum amount of injury to the vessel. Each has disadvantages. The Beta Propriolactone method is more complicated, its acid properties require careful neutralization, and there is the explosion hazard with ethylene oxide.

The lyophilization process consists of two steps: quick freezing to −70°C. and drying under vacuum. The vessel is sterilized in an artery tube in which it will be stored at the end of the process. This eliminates the danger of contaminating the sterile vessel during transfer. Artery tubes are of pyrex, 28 mm. in diameter and up to 50 cm. in length with machined standard taper joints at the open end so that they may be attached to the vacuum tight lyophilization apparatus. Immediately after sterilization the vessel is submerged in a dry ice acetone bath at −70°C. (Figure 2). This rapidly freezes the tissue in such a fashion that only small crystals are formed and denaturing of the protein is minimum. The vessel is kept at this temperature until lyophilization.

The lyophilization or drying process is carried out under a vacuum of about one micron of mercury which is achieved by means of a mechanical pump augmented by an oil diffusion pump, (Figure 3). A system of pyrex tubing containing two or more condensation traps is attached to the pumps. From this system standard taper joints project which fit exactly the



**Figure 3. The lyophilization apparatus is pictured showing a vacuum line from the mechanical pump, the oil diffusion pump, the pyrex tubing with liquid nitrogen traps, attached artery tubes and dry ice acetone baths.**

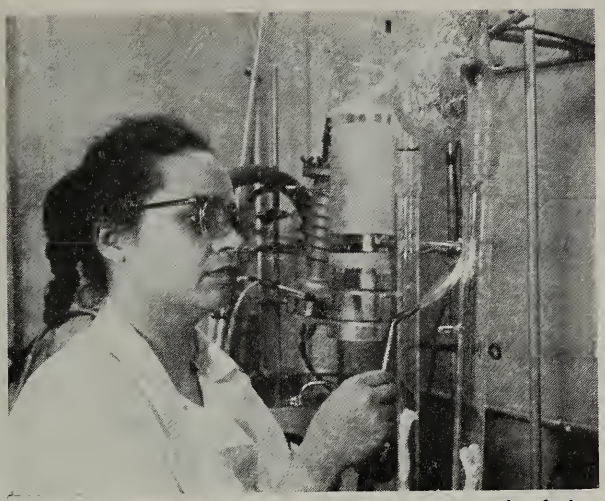


**Figure 4. The sterile lyophilized aorta is being sealed in the tube under vacuum. The side arm for easy opening can be seen.**

ends of the artery tubes. The artery tubes containing the sterile vessels are attached, and the pumps turned on. The condensation traps are filled with liquid nitrogen which is at a temperature of −196°C. The portion of the artery tube containing the vessel is kept in the acetone-dry ice bath at −70° for the first hour of drying. This is done to prevent the vessel from partially thawing, which would result in the formation of larger crystals and injury of the tissue. After a high vacuum has been achieved, the heat lost in sublimation of the ice crystals keeps the artery frozen and the dry ice bath is removed. A drying period of eight or ten hours at one micron of mercury or less of pressure is felt to be sufficient to sublime 96% or more of the ice crystals from an average artery. The water vapor from the artery precipitates on the condensation traps because of the much lower temperature of liquid nitrogen. A gross estimate of the degree of drying of the vessel may be made by virtue of the fact that the temperature of the tube approaches room temperature as drying near completion.

The artery tubes are constructed with a slight thickening of their wall four cm. below the taper joint. This makes it possible to seal them with an oxygen torch while they are still under vacuum, (Figure 4). The tube is constructed with a nipple-like side arm below the level at which it is to be sealed off. At the time the tube is to be opened for the use of the vessel, this side arm may be broken off first, thus breaking the vacuum and making it easier to break the thick pyrex tube.

The artery may be reconstituted by placing it in saline for 30 minutes. Some authorities have advised adding an antibiotic to the saline. Some also have advised breaking the ampoule beneath the surface of the reconstituting fluid so that the tissue spaces in the vessel will not fill with air and reconstitution will take place more rapidly and completely. According to present thought, lyophilized vessels, sealed in tubes under a vacuum, may be stored at room temperature for as long as two years.

In addition to thoracic and abdominal segments of human aortas, we have lyophilized entire infant aortas, segments of human saphenous veins, pig aortas for use as shunts, and dog aortas for experimental transplants. We anticipate being able to process human femoral arteries in the near future. In connection with this we have obtained the co-operation of the embalmers' union and we are now awaiting a statement of approval from the undertakers' association so that femoral vessels may be removed in a manner that would not make their work more complicated and difficult.

Up to April, 1956, approximately 160 specimens have been lyophilized. About 95 specimens have been sent out and about 52 used. The ease of transportation of the lyophilized vessels makes it possible to send a number of varying sizes to a surgeon so that he may have a choice at the time of operation. Since they are returnable, the vessels may be sent even when there is only slight indication that a graft may be necessary. This explains the large number of vessels sent out, relative to the number used. An index file where the pertinent information concerning each vessel is recorded on a card is kept at the bank. Two forms go with each vessel sent out. The first is for the information of the surgeon, giving a description of the vessel with measurements and comments, and instructions for reconstitution. The second is a questionnaire with a description of the operation to be returned if the vessel is used.

The Chicago Branch of the American Red Cross has been kind in assuming the responsibility of delivering the arteries where needed.

## SUMMARY

The organization and early function of a Municipal Artery Bank serving the Greater Chicago Area has been described. The demand

for arterial segments is increasing and early technical difficulties have been overcome. A progress report containing the fate of implanted segments together with the clinical results will be presented at a future date.


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# The Multiphasic Treatment of Acne Vulgaris


**Samuel M. Bluefarb, M.D., Chicago**


ACNE vulgaris is a normal accompaniment of adolescence. A knowledge of its pathogenesis appears pertinent, since a better understanding of the condition gives a logical basis for therapy. According to current concepts, acne is due to circulating androgenic hormones acting on the "shock organ," the pilosebaceous apparatus (hair follicle and sebaceous gland). In view of these concepts, the therapy of acne should include (1) reduction of sebaceous gland overstimulation, (2) reduction of intrafollicular irritation, and (3) therapy for removal of comedos. Although these are the essential features in acne, other important contributing factors may exist such as foci of infection, insufficient secretion of thyroid hormone, iron deficiency anemia, application of skin "creams" and other external irritants, seborrheic dermatitis of the scalp, or nervous stress. Therefore, it is essential to treat every facet, however minor, which may play an etiologic role. With our present knowledge, the therapy of acne must be multiphasic.

*Therapy to Reduce Sebaceous Gland Overstimulation*: As our knowledge of acne increases, roentgen ray therapy is being used less frequently. However, it is still the most effective single modality for decreasing gland activity. Roentgen rays, if correctly administered, in standard dermatologic quality and dosage, never result in permanent damage to either the skin or any internal organ[1].

Another method of counteracting excessive sebaceous gland activity is to control the preponderance of androgenic hormone by administration of estrogen therapy. For women, 0.625 mg. of conjugated water-soluble estrone or 0.5 mg. of diethylstilbesterol may be given daily for two weeks preceding menstruation. This therapy sion, as well as the public in general, has a right to ask for a re-evaluation of this problem.
is continued for four months and the results frequently are excellent in young women. For men, we administer this therapy only to those having severe scarring and cystic acne. The same dosage is given to men for two weeks each month for not more than four months. No undesirable effects have been noted in young men treated with this dosage.

*Therapy to Reduce Intrafollicular Irritation*: Prevention of the accumulation of follicular irritants due to ingested food and drugs also must be considered in the therapy of acne vul-


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garis. It is important to impress upon these young people that they are not dieting but merely avoiding certain foods and drugs known to produce or cause exacerbations of acne. The following foods should be avoided: Chocolate, nuts, pork and pork products, seafood, eggs, and excessive ingestion of milk. The halogen group of drugs—bromides and iodides—are avoided because of their tendency to produce intrafollicular irritation. There usually is a sluggish flow of oil associated with the intrafollicular irritation, thus increasing the possibility of secondary infections of the pilosebaceous apparatus.

*Therapy for Control of Comedo and Papule Formation*: Proper care of the pilosebaceous orifices is essential to prevent formation of comedos, or blackheads, at the opening of the pilosebaceous glands. When comedos are not removed they act as a plug, thus damming up secretions and resulting in papules, pustules, and even cystic lesions.

Two approaches may be directed against the removal of the comedo: Topical therapy and the oral administration of vitamins A and C. The most simple topical therapy is the use of soap and water. Usually, however, peeling is required. Lotio alba, a polysulfide lotion, has been the time tested preparation for acne vulgaris. When prepared, it is probably still the most effective topical agent. However, it has been impossible to procure freshly prepared lotio alba for each application.

This difficulty was recently overcome with a new product consisting of a stabilized sulfurated potash coated with an equimolecular film of zinc sulfate, separated by a layer of an inert colloid. When a prescribed volume of water is added by the patient to the stabilized powder, a completely fresh polysulfide solution is produced. As the product is packaged to provide for individual applications, the degree of drying activity can be controlled by varying the ratio of water to the powder.

The results from the use of this preparation on more than 200 acne vulgaris patients were gratifying. These patients were instructed to apply this lotion to one side and a resorcin-sulfur lotion to the opposite side of the face. The use of this lotion, Pronac®[2], resulted in a greater astringency and drying action than occurred on the side of the face treated with resorcin-sulfur lotion and was, therefore, preferred by patients. The best results were obtained in patients whose skin felt a little "tight" and dry but did not become reddened.

In another study[3] it was found that the combined use of aqueous vitamin A, 100,000 units daily and 1 gram of vitamin C daily, are useful agents in correcting the follicular plugging of acne vulgaris.

*General Therapy*: Seborrhea of the scalp, also a sebaceous gland disorder, frequently accompanies acne. Unless this condition is controlled, the acne form process will be difficult to alleviate. External follicular irritation should be avoided. These irritants would include the wearing of rough garments such as sweaters and wool shirts, which come into contact with back and shoulders; the use of cosmetic creams and oils; and contact with oils, greases, tars, and chlorinated substances.

Foci of infection and secondary infection of the pilosebaceous apparatus is best counteracted by removing the focus or by treatment with wide spectrum antibiotics in small oral doses. Low thyroid output should be corrected with thyroid therapy and iron deficiency anemia, with iron therapy.

## SUMMARY

The treatment of acne vulgaris is multiphasic. Therapy is directed against the overstimulated sebaceous gland with roentgen rays and estrogens. Therapy for the intrafollicular irritation consists of avoidance of certain foods and drugs. To remove the comedos, topical therapy with patient prepared lotia alba is recommended as well as vitamins A and C orally. General therapy would include the treatment of the seborrhea of the scalp, avoidance of external follicular irritation, treatment of secondary infection, and the correction of low thyroid output and secondary anemia, if present.

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# Skin Eruptions Caused or Aggravated by Sunlight

Otto C. Stegmaier, M.D., Moline

BEFORE discussing eruptions due to sunlight, a brief review of the position of the sun in relation to the electromagnetic spectrum of radiant energy is apropos. Radiation from the sun extends from the ultraviolet to the infrared, from 2,900A° to 30,000A°. Wave lengths shorter than 2,900A° are absorbed by the atmosphere and are not encountered on exposure. Between 2,800A° and 3,100A° the sun is exhibiting its most intense biological effects — its antirachitic and carcinogenic effects. The erythema spectrum, or burning effect, is between 2,900A° and 3,100A°. This also is the wave length that causes pigmentation. Above 3,000A° existing pigmentation is intensified by sunlight. Window glass filters out the sun rays below 3,200A° but transmits higher wave lengths.[1]

In discussing the effects of sunlight, distinctions must be made between the various types of skin. Normal skin has varying tolerances to ultraviolet radiation. The thin skinned, red headed, blue eyed person, because of lack of protective faculties, tolerates only small amounts of exposure; the skin reacts not only more violently with an acute sunburn but shows a greater tendency to chronic solar damage and skin cancer. The skin of the blond is next most vulnerable while the brown eyed brunet is least vulnerable. However, he is not immune to the dermatoses caused by sunlight if the exposure is great enough.

Skin eruptions caused by sunlight are enumerated as follows:

I. *Sunburn.* Common manifestations of sunburn will not be described. Sunburn sequelae less familiarly known are:

A. Herpes simplex.

B. Folliculitis.

C. Vitiligo.

D. Chloasma (patches of increased pigmentation).

E. Increased sensitivity to further sunlight exposure.[2]

II. *Farmers' and Sailors' Skin* (chronic solar dermatitis), the precancerous skin changes produced by sunlight. On exposure to much sunlight these persons develop on the exposed surfaces premature senile changes which occur most frequently in the light or red haired person. Lesions consist of atrophic scaly, freckled, and hyperkeratotic changes. Connective and elastic tissues also undergo a change, producing yellowish discoloration of the skin. The lips become whitened and dry and fissure readily. These changes are precursors of skin cancers.

III. *Skin Cancers.* There is good evidence that sunlight is one of the main causes of skin cancer. The majority appear on exposed surfaces such as the face and dorsum of the hands, and they are much more common in farmers, construction workers, and others exposed continuously to the sun. Southern climates have more clear days and more sunlight than northern climates; consequently, skin cancers are more common in southern latitudes. For example, Georgia and North Carolina have about four times the number of skin cancers per capita as that found in the Chicago area.[3]

Sunburn and chronic solar damage can be prevented by gradual exposure to sunlight. The first exposure must be short and the time increased gradually until a good tan is developed. This increases melanin in the skin and thickening of the surface layer, which prevents deep penetration of the sun's rays. The use of adequate clothing is helpful. This means a handkerchief about the neck, long sleeved shirts, and a wide brimmed hat. Chemical sun screens also are of value. The main and most effective is para-aminobenzoic acid that has an action spectrum of around 3,000A°. This selectively filters out the

*Presented before Section on Dermatology, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1955.*

erythema and carcinogenic effects of sunlight, if the preparation is applied often and adequately. It must be re-applied after swimming to be effective. One of the best contains 15 per cent para-aminobenzoic acid in vanishing cream base (Rothman).[4]

IV. *Hydroa aestivale,* which manifests itself by blisters of various sizes on the skin, appears usually in childhood and occurs each year in spring and summer. Successful therapy with gonadotrophic hormones has been reported.[5]

V. *Xeroderma Pigmentosum* is a familial disease characterized by lack of inherent protection against sunlight. The skin, at an early age, develops freckles, keratoses, telangiectases, and white spots. These go on to skin cancers. The children do not live to old age as they usually die of metastatic carcinoma arising from one of the skin cancers. There is one of these families in southern Illinois whose members avoid the sun entirely by working in the mines during the day and conducting all of their business and social affairs after sundown. This is probably the only way to prevent their early death.

VI. *Polymorphic Light Eruptions.* This group of dermatoses due to sunlight manifest themselves in four types:

A. Plaquelike type, the most common, has been described excellently by Lamb[5]. It is characterized by purple-pink indurated plaques occurring predominately behind the ears and on the neck. They are much more common in the fair but may occur in the dark-skinned race as well.

B. Contact eczematous type which resembles dermatitis venenata.

C. Papular and prurigo-like type.

D. Erythematous (erythema solaris perstans or erythema muliforme) type.

As mentioned above, the plaque type is the most prevalent. The exact etiology is unknown, except that the eruptions are due to sunlight. It has been postulated by Lamb[6] that these eruptions may indicate a deficiency of hormones, particularly testosterone, and he has shown that the condition can be cured in some instances by stimulating the pituitary to produce more androgens. The best treatent, outside of steroids, which is a long and expensive form of therapy, is by the use of the antimalarial drugs, atabrine and chloroquine, which are suppressive.[7] The medication must be taken during the summer months and symptoms can be controlled in around 75 per cent of the cases. It is not a cure.

VII. *Solar Urticaria.* These reactions are of two types. In one, urticaria is brought on by exposure to long ultraviolet rays, usually less than 3,700A°[8]. In the second type, urticaria is produced by rays in the blue zone of visible light, 4,000A° to 5,000A°[9]. Antihistaminic products have been used to reduce sensitivity in the second group.

VIII. *Photosensitization Due to Drugs Ingested.* Certain chemicals, particularly the sulfonamides, barbiturates, and Thorazine® —when taken internally—sensitize the skin to ordinary sunlight exposure.

IX. *Photosensitization Due to Chemicals or Plants* applied to the skin, followed by sunlight exposure. Most important are the coal tar derivative chemicals and certain plants:[10]

A. Oil of bergamot, which is contained in perfume and cologne, is a frequent producer of hyperpigmentation. Pigmented spots appear after the application of perfume and exposure to sunlight.

B. Coal tar and pitch may produce keratoses and skin cancers.[11]

C. Paradoxically, some of the derivatives of para-aminobenzoic acid, particularly the esters of para-aminobenzoic acids contained in some of the commercial suntan preparations, sensitize the skin to sunlight.[12]

D. Plants[13] : parsnips, yarrow, meadow grass, gas plant, common rue, persian lime, and figs. Contact with any of these plants followed by sunlight in pre-disposed individuals will produce a reaction of the skin manifested either by blisters and/or pigmentation. The chemicals responsible for this reaction belong to the furocumarin family of drugs; a member of this family is used in the treatment of vitiligo.

## DERMATOSES AGGRAVATED BY SUNLIGHT

I. *Lupus Erythematosus.* Both the chronic discoid forms and the systemic forms may be severely aggravated by exposure to sunlight. In the systemic form, death may result following a prolonged sun exposure.

II. *Pellagra* is also known to be aggravated by sunlight exposure.

III. *Porphyria.* This is an inborn fault of metabolism characterized by the excretion of abnormal kinds and amounts of porphyrins. These may be detected in the urine by the utlilization of the Wood light. The porphyrias have been divided into two groups by Watson:[14]

A. Erythropoietic Porphyria. In this group, symptoms begin in early childhood in the form of a bullous eruption on exposed areas. The urine is red and the teeth and bones often are red. The fluorescent material is found in some of the normoblasts of the bone marrow. Splenectomy often is helpful.

B. Hepatic Porphyria. In contrast to the above, the disturbed metabolism of porphyrins is in the liver and not in the bone marrow.

a. Acute Intermittent Porphyria. Sensitivity to light is not common, although hyperpigmentation may occur. This group characteristically has abdominal colic and psychic disturbances.

b. Porphyria Cutanea Tarda. This benign type, so well popularized in American literature by Brunsting,[15] appears initially in adult life and is associated with hepatic dysfunction. Mild sensitivity to light and trauma exists. The latter manifests itself by bullae over the sides of the neck and the knuckles. Symptoms frequently are precipitated by hepato-toxins (alcohol and barbiturate).

c. Mixed types. A combination of a and b.

d. Latent Porphyria. The urine of these persons, who are symptom free, contains abnormal porphyrin.

IV. *Bacterial Skin Infections* such as infectious eczematoid dermatitis and seborrheic dermatitis can be aggravated by sunlight exposure. Koebner's phenomenon in lichen planus and psoriasis may result from intense sunlight.

V. *Vitiligo and Albinism.*

VI. *Pityriasis Rubra Pilaris and Keratosis Follicularis.* New lesions may develop in areas exposed to sunlight.

## SUMMARY

Enumeration, prevention, and management of many dermatoses caused or aggravated by sunlight have been given.

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# Serotonin

**Earl P. Benditt, M. D., Associate Professor of Pathology, University of Chicago**

*Dr. Benditt*: Serotonin was discovered more than 40 years ago. It was found that serum had a vasopressor and muscle stimulating action which over the years was traced to the platelets. In the 1940's Erspamer in Italy demonstrated a substance with similar properties in the salivary glands of the octopus, the skin of amphibians, and the gastrointestinal tract of all vertebrates except a few fishes. This material he named "enteramine". He made the further association of enteramine with the enterochromaffin or argentaffin cells. 5-hydroxytryptamine was extracted and identified by Rapport and co-workers in an intriguing bit of biochemical detection. It was subsequently synthesized by two groups of investigators in the pharmaceutical industry. When the synthetic material became available, it was quickly shown that enteramine and serotonin were identical.

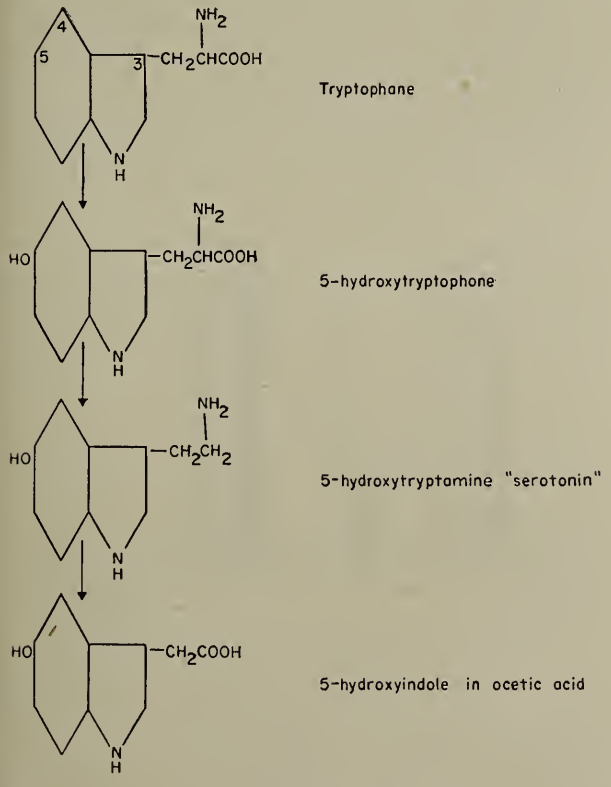



**Figure 1. Source and metabolism of serotonin.**

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Serotonin is derived in the animal body from tryptophane. In Figure 1 are shown the probable intermediates in the reaction: Tryptophane is converted to 5-hydroxytryptophane. The enzyme system for this step has not yet been located or characterized. The 5-hydroxytryptophane is then decarboxylated to the amine, serotonin. The enzyme system for this step is present in liver, kidney, gastrointestinal tract, and brain of several species now examined. Finally serotonin is oxidatively deaminated by a monamine oxidase and the resulting 5-hydroxyindole acetic acid is excreted in the urine. A man normally excretes daily about 10 mg. of 5-hydroxyindole acetic acid in his urine or an amount equivalent to about 2% of his tryptophane intake (i.e., 500 mg/day). In patients with malignant carcinoids the daily excretion of 5-hydroxyindole acetic acid may rise as high as 500 mg.

Serotonin is widely distributed in biological organisms. In addition to its presence in platelets, the gastrointestinal tract of vertebrates, the salivary glands of the octopus, and the skin and venom glands of toads it has been found in brain, particularly in the hypothalamus, by us in the mast cells of the rat, in the venom glands of the wasp, and in the spicules of the cowhage which are used as itching powder.

The effects of serotonin when injected into the mammalian body are manifold: It elevates blood pressure after transient lowering; causes

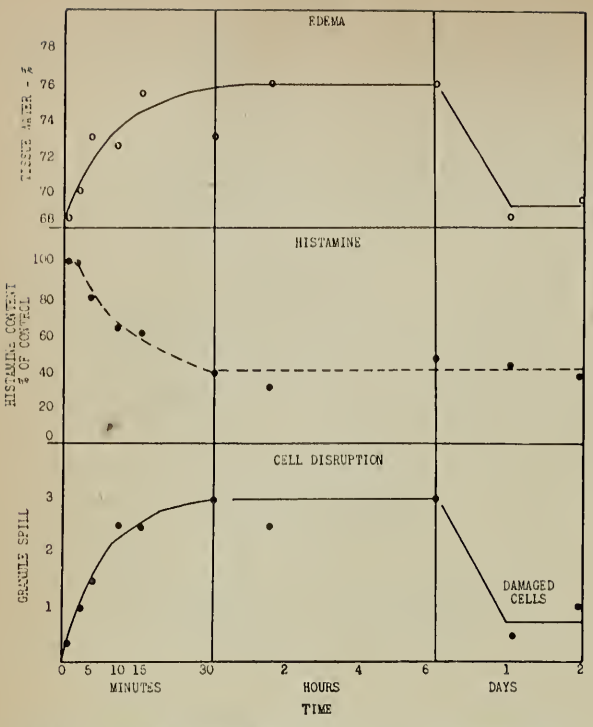


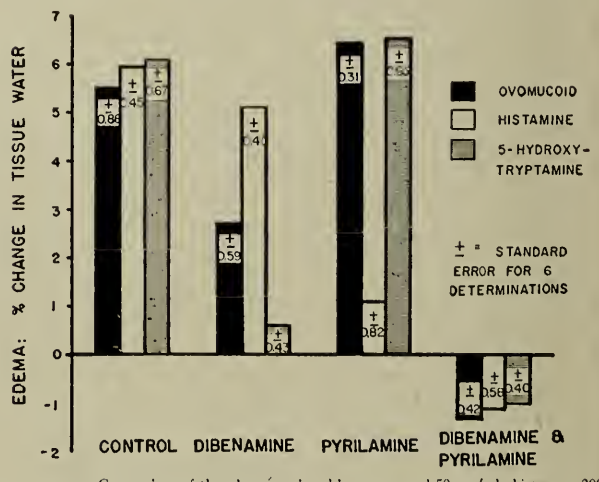

**Figure 2—The relationship in time between mast-cell disruption, histamine release, and edema formation.**

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a peculiar flushing; it is supposed, but not proved, to operate in the hemostatic mechanism; it is said to be an antidiuretic principle. The most recent function ascribed to it is that of a neurohumor and perhaps one important in the manifestations, if not the mechanism, of some of the psychoses.

Our studies on serotonin began in a discrepancy between the expected and the actual outcome of an experiment: we have been investigating the mechanism of egg-white edema in rats using this phenomenon as a model for the hyperemic edematous reactions commonly seen in many inflammations. We had found that the injection of egg-white, or its ovomucoid fraction produced disruption of mast cells and release of their contained histamine. (Figure 2) Following a single large dose of ovomucoid the majority of mast cells were damaged and the tissue histamine dropped to a low level. In spite of this a second dose of ovomucoid elicited the maximal edematous response. It occurred to us that serotonin might be present in the tissue along with histamine. Despite the fact that the emphasized action of serotonin was vasoconstrictor we tried it and found, to our surprise, that it had much more potent capacity than histamine, in the rat, to cause increased capillary permeability: an equivalent reaction in the skin of the rat is caused by 1 gamma per ml. of serotonin and 200 gamma per ml. of histamine. (Figure 3.) In a subsequent series of experiments we were able to show that serotonin is present in the skin of rats in association with histamine and mast cells and we have in addition been able to extract histamine and serotonin from isolated rat mast cells. There is about 1 part serotonin to 24 parts of histamine. By using a pharmacologic antagonist of histamine (neoantergan) and an antagonist of serotonin (dibenamine), each having a specific effect, we were able to show that both histamine and serotonin were released or activated when ovomucoid and other agents (dextran, 48/80, and testis extract) caused damage to mast cells. Furthermore appropriate concentrations of serotonin and histamine in the ratio of 1:24 injected subcutaneously in the rat mimicked the effects of the mast cell damaging agents. Neither serotonin nor histamine was found to cause damage to mast cells. These experiments open the possibility that serotonin may participate along with other things, including histamine, in the development of the hyperemia and edema of inflammation.

Serotonin is associated with enterochromaffin cells; enterochromaffin cells are present through-




Comparison of the edema produced by ovomucoid 50 μg /ml., histamine 200 μg./ml., and 5-hydroxytryptamine 1 μg./ml., and also the inhibition of edema produced by these agents with dibenamine 8 mg./kg. and/or pyrilamine 4 mg./kg.

**Figure 3** Reproduced, with permission of the editor and publisher, from THE JOURNAL OF EXPERIMENTAL MEDICINE 102: 309-412, 1956.

out the gastrointestinal tract of most mammals and are the constituent cell of carcinoid tumors. These cells give a number of characteristic histochemical reactions of which the following four are most commonly used: (1) they turn brown with chromate; (2) they reduce amine silver solutions directly at mildly alkaline reactions; (3) they yield bright reddish-orange colors with diazonium salts and (4) they fluoresce yellow-green in ultraviolet light after formalin fixation. These reactions are also given by serotonin and 5-hydroxytryptophane and are mainly the reactions of the 5-hydroxyindole ring structure.

It has been shown recently that reserpine releases serotonin from the gastrointestinal tract and brain of rabbits. We, therefore, examined the stomachs of rabbits and the duodenums of guinea pigs for serotonin by extraction and assay and histochemically for enterochromaffin cells. Within four hours following the intraperitoneal injection of 5 mg/kg of reserpine the serotonin content of the guinea pig duodenum dropped from an average value of 20 gamma/ gm. to 2 gamma/gm.; the stainable enterochromaffin cells were reduced from 18/high power field to 3/high power field. By four days following the single injection the cell counts and serotonin levels returned to normal. These findings are consistent with the notion of Brodie and Udenfriend that reserpine may act by lowering the tissue content of serotonin. It also is consistent with the idea that the argentaffin material of the enterochromaffin cells is serotonin or a close relative.

We have also been able to show that the tranquilizing drug, chlorpromazine, is an antagonist to serotonin in vivo and in vitro in rats. This may be an important part of its mechanism of action.

Much remains to be discovered about serotonin, its derivation and its physiological and pathological interactions. Several compounds of related chemical structure have been found to produce behavior changes in mice. Lysergic acid diethyl amide (L.S.D.) produces hallucinations and schizoid manifestations in man. In animals it has been shown to antagonize certain effects of serotonin. When the current flurry of excitement dies down and more sound and verifiable information is at hand we shall be able to assess better the role of these several agents in biology and medicine.

*Dr. Robert J. Adolph* (Assistant in Medicine): Right heart failure and right sided anatomical alterations are frequently seen in patients with malignant carcinoid tumors. Would you comment upon the pathogenesis of the cardiac changes in this syndrome?

*Dr. Benditt*: Serotonin is capable of causing pulmonary hypertension. Pulmonary hypertension might be the cause of the cardiac changes, at least in part. As yet the exact mechanism is unknown and this is pure speculation.

*Dr. Robert J. Kaiser* (Instructor in Medicine): Do your studies suggest any mechanism for the pressor action of serotonin?

*Dr. Benditt*: No, they do not, Furthermore, I don't feel that our studies on serotonin, confined as they have been to special systems, allow us to generalize wildly on its other systemic effects.

*Dr. Robert M. Kark* (Professor of Medicine): What is the effect of ovomucoid injections on the platelets of the rats?

*Dr. Benditt*: We have examined these elements following i.v. ovomucoid and found no depression but some apparent rise and no depresspression of serotonin content.

*Dr. Kark*: Are the mast cells in the rat identical with so-called basophils?

*Dr. Benditt*: Some anatomists are inclined to separate tissue mast cells and blood basophils. My own current stand is that these are very similar, if not identical cells.

In closing I wish to acknowledge the generous support of this work by grants from the U.S.P.-H. S. (#H-2141), The Illinois Department of Welfare, and The American and Chicago Heart Associations.

# Obstetrical Anesthesia in The Non-Teaching General Hospital

W. R. Freeman, M.D., Champaign

THE literature on obstetrical anesthesia is voluminous but this paper discusses the problem particularly from the aspect of non-teaching general hospitals in smaller urban areas where qualified anesthesia personnel are available only for emergencies or operative deliveries.

The pain of labor is real and the obstetrician is obligated to alleviate discomfort within the limits of safety for mother and fetus. Safety is the crux of the problem, as most anesthesia agents will provide adequate relief.

Merrill and Hingston[1] recently reported that a survey of 218 major maternity centers throughout the United States which deliver more than 2,000 babies annually, revealed 66 maternal deaths and 8 ensuing fetal deaths in utero resulting from inhalation of vomitus during obstetric anesthesia induction. The most common offender was ether alone; nitrous oxide ranked second. These deaths occurred in the five year period 1948-1953 and were proved by autopsy findings.

Hillman and Hingston[2] report that maternal deaths resulting from or relating to anesthesia are in fifth place, just after heart disease as a contributor to maternal mortality.

In downstate Illinois, reporting through the Bureau of Maternal and Child Health, 18 deaths were attributed to obstetrical anesthesia in the five year period, 1949-1954. Inhalation anesthesia caused 14 deaths of which 10 resulted from aspiration of vomitus. Nitrous oxide and cyclopropane, cyclopropane alone, ethylene, open drop ether and combinations of these agents were incriminated. One death was due to caudal anesthesia and two to spinal but one due to spinal also received ether. One death was due to Pentothal® and d-tubocurarine. Ten deaths were associated with vaginal delivery, seven with cesarean delivery, and one with ruptured ectopic pregnancy.

*Presented before the Obstetrical Section, 115th Annual Meeting, Illinois State Medical Society, Chicago, May, 1955.*

The same type statistics are not available for Chicago and the only information made available to us was the cause of death as given on the death certificates, as reported by the Chicago Board of Health. Four deaths were listed as due to anesthesia during the same 5 year period; two in 1949, one in 1950, and one in 1951. We were unable to determine the agent used, type of delivery, or the time of death in relation to the anesthetic administered. Six obstetrical anesthetic deaths were reported for Chicago in 1954 and one in the first quarter of 1955.

No attempt has been made here to assess the number of fetal deaths resulting from anesthesia.

Twenty-two deaths in Illinois in 5 years attributed to anesthesia make the generally unsatisfactory status of anesthesia in obstetrics all too apparent. If this is a problem in maternity centers where, in many instances, the entire 24 hour period is covered by trained anesthesia personnel, it is a far greater problem for those of us practicing in the smaller urban areas in non-teaching hospitals.

The Annual Summary of the Department of Public Health listed the following data for Illinois in 1953:

| | | | | | |
|---|---|---|---|---|---|
| 17 | hospitals | with | under | 100 | deliveries a year |
| 29 | " | " | 100-249 | " | " |
| 52 | " | " | 250-499 | " | " |
| 53 | " | " | 500-999 | " | " |
| 56 | " | " | 1,000-1,999 | " | " |
| 12 | " | " | 2,000-4,500 | " | " |

Of the states' total of 197,458 babies in 1953, 57,391 were delivered in hospitals with less than 1,000 total deliveries annually. In most of these deliveries the obstetrician was responsible for providing anesthesia as well as obstetrical care, as trained anesthetists or anesthesiologists usually are available only for emergencies or operative deliveries in the smaller institutions. In the circumstances, the obstetrician either must depend upon the circulating nurse or other untrained persons for some type of inhalation anes-

thesia for routine patients, or he must choose some type of local or conduction anesthesia which he can administer to give adequate relief of pain while preserving the welfare of the mother and infant.

For the past nine years the obstetrical department of the Christie Clinic has been conducting prenatal instruction classes for expectant parents, one of which is devoted to presenting a black and white film entitled "Normal Delivery," suitably edited for lay consumption. This film is one of a normal delivery, using pudendal anesthesia. Supplementary remarks by one of us explains the problems of anesthesia and delivery. The importance of relaxation during the first stage of labor is stressed and a few simple exercises in preparation for labor are given.

In our experience, the few hours devoted to these classes have been gratifying in that patients understand more completely the physician's problems in obstetrics, more particularly in regard to anesthesia, and these women are far more co-operative than those who have not attended the classes. Admittedly, at the inception of this program, there was some feeling that we were pampering the patients and wasting valuable time. We now consider this instruction an integral part of prenatal care and believe it to be instrumental in obtaining patient co-operation and acceptance of the preferred types of analgesia and anesthesia.

A brief discussion of agents used for analgesia and anesthesia seems indicated. Our patients usually receive Seconal® 200 mg. (gr. iii) when dilatation of the cervix to three to four cm. has occurred. This may be followed with Demerol® 100 mg. when needed. Demerol usually is not repeated more than once but patients delivered under pudendal block are better controlled if they have received Demerol during the first stage of labor within two to three hours of delivery.

Scopolamine is not used. Inhalation anesthesia is used infrequently because of lack of trained personnel and because of the inherent dangers associated with the improperly prepared patient. Management of deliveries with the patients awake and co-operative has been more satisfactory than keeping the patient in a semi-conscious or unconscious state with general anesthesia.

Trichlorethylene (Trilene®), self-administered, is useful in many instances near the end of the first stage of labor and occasionally for rapidly progressing multigravida during the second stage. Trilene frequently is useful to supplement pudendal block as in a difficult forceps delivery. Trilene should always be self-administered. The mask should not be held in place by a nurse or assistant. Deepening of the anesthetic beyond the first plane of surgical anesthesia is characterized by bradycardia or irregular heart action and by the onset of curiously rapid, shallow respirations.

Ether, by open drop occasionally is used with contractions in rapidly progressing multigravida during delivery, more for psychological reasons than for anesthesia. Ether anesthesia usually is indicated when uterine relaxation is required, as in the rare version and extraction or for manual removal of the placenta. It often contributes to excessive loss of blood.

Cyclopropane and oxygen are used in cesarean section if shock or hemorrhage is present or pending. In these cases we endeavor to have the infant delivered within 10 minutes of induction of anesthesia. Our pediatricians have more infants to resuscitate when cyclopropane is used and they, as well as the obstetricians, prefer conduction anesthesia for cesarean section.

All the precautions of grounding and approved electrical wiring must be constantly observed with cyclopropane. Pituitrin should not be used because of the danger of cardiac irregularities, leading to ventricular fibrillation.

Greenhill[3] particularly has been urging the use of direct infiltration anesthesia for years, as the safest of all types of anesthesia.

It was not until the introduction of Xylocaine,® an agent that diffuses widely and rapidly through the tissues, that the use of pudendal nerve block became more dependable and less likely to fail because it was no longer necessary to be absolutely accurate in injecting the pudendal nerve to achieve good results. Since pudendal block has much merit, it might be useful for us to review the technique briefly.

The excellent paper by Klink[4] from which diagrams and excerpts are reproduced in the 1953-54 Year Book of Obstetrics and Gynecology is recommended to those interested.

Technique: The five inch 20 needle of a syr-

inge containing 10 cc. of 1% Xylocaine is inserted through the perineum between the ischial tuberosity and the anus, somewhat nearer the anus than the tuberosity and advanced through the ischiorectal fossa toward the posterior surface of the ischial spine.

Guided by the finger in the vagina, the needle, as it approaches the ischial spine is pushed posterior to the tip by the guiding finger. If properly placed in the pudendal canal the needle can be pulled back and forth slightly without resistance. Aspiration is made to verify the position outside of the pudendal vessels.

Three or four cc. are deposited beneath the inferior tip of the spine, then advanced to the superior tip and 3 or 4 cc. injected. It is then advanced beyond the spine and 4 cc. injected to block the hemorrhoidal branch and the posterior femoral cutaneous nerve. This is repeated on the opposite side. Anesthesia is adequate in five or 10 minutes and persists for 30 minutes or longer. Sensitivity to Xylocaine is rare. It has the advantage of being readily prepared, yet disseminates through the tissues as well as solutions with hyaluronidase added. There is no apparent effect on uterine contractions as there may be with the use of preparations to which epinephrine is added.

Considerable manipulation can be carried out when necessary. Episiotomy and forceps when necessary or Piper forceps to the after coming head in breech may be readily accomplished if reasonable gentleness with manipulation is observed. Fewer forceps deliveries are necessary than with saddle block or general anesthesia as the patient is completely co-operative and muscle tone is unaffected.

For the patient with a lower pain threshold or where delivery is moderately difficult, self-administered Trilene usually is all that is needed additionally to complete delivery, after which repair may be completed with local anesthesia.

Pudendal block is excellent for breech deliveries and for uncomplicated cephalic presentations. It is contraindicated in patients with a history of sensitivity to local anesthetics and in cases of massive dermatitis and furunculosis of the perineum.

Saddle block has been used by us since 1946 according to the technique orginally described by Adriani[5]. Our group has used heavy Nupercaine® in hyperbaric solution over 2,400 times for delivery, giving the spinal with complete dilatation in the primigravida and usually when eight cm. to complete dilatation if used in multigravida. A single injection is used and not repeated. Spinal headache has been the predominant complication but its frequency has decreased as the technique has improved. There were four extensive perineal hematomas which were not detected early because of prolonged perineal anesthesia. Persistent occiput posterior positions requiring rotation were more frequent. Others have reported serious neurological complications and maternal deaths have been attributed to the spinal technique.

In elective cesarean section, where there is no question of shock, hemorrhage or hypotension, low spinal is preferred to general anesthesia and is given by single injection. It usually is possible to restrict the level of anesthesia to within 2 cm. above the umbilicus, or within the 9th thoracic segment. Ephedrine 25 mg. is given intravenously at the instant the spinal injection is made to combat hypotension, and 100% oxygen is administered. No sedation is given preoperatively. Pentothal sodium intravenously usually is used after the cord is clamped.

One of the chief disadvantages to spinal anesthesia is patient resistance and the tendency for patients to attribute unrelated symptoms such as backache occurring days to weeks later, to the spinal technique. Our use of saddle block has decreased as our use of pudendal block has increased. We are attempting to relegate spinal block to patients where a difficult delivery is anticipated.

Saddle block, properly administered with due regard for contraindications has, in our hands, provided satisfactory relief of pain without serious fetal or maternal consequences.

## SUMMARY

The problem of providing obstetrical anesthesia which is effective yet safe for mother and fetus is difficult to solve, particularly in the nonteaching general hospital where full-time anesthesia service is not available.

It behooves the physician whose practice is either partially or completely devoted to obstetrics to familiarize himself thoroughly with the anesthetic methods of his choice as he has a double responsibility to fulfill.

The danger of inhalation anesthetics has been

stressed; the advantages and disadvantages of spinal anesthesia have been reviewed.

From the standpoint of providing an effective, safe, simply administered second stage anesthetic for delivery, pudendal block has proved to be closer to the ideal for general usage.


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## The other side of Freud

Freud had a hard life and the suffering it entailed left a mark on him in more ways then one. The first part of his life was spent in dire poverty, even at times to the point of hunger. When his practice improved he had to support several people besides his wife and children. Later, the inflation that followed the first world war swallowed up all his savings and insurances, so that he had to start again in old age. His work met as bitter an opposition as has fallen to the lot of any pioneer in science. He was reviled as either an evil-minded villain or someone with a diseased brain pretending that his own delusions were clinical observations. A chapter of the calumnies directed against Freud personally and his work would be long indeed, nor is it even yet at an end. He bore all this hostility with considerable fortitude and never deigned to reply to it in public; in private he even derived a certain amount of amusement from the more extreme examples. I remember his remarking once: "My opponents may abuse my doctrines by day, but I am sure they dream of them by night."

Freud, therefore, had no reason to think of life as something easy. It was something to be endured and any enjoyment or happiness was a bonus, not something one had an inherent right to expect. He certainly was not a spoilt child. Nor did his experiences give him a high opinion of mankind's moral nature. Much of what passes as such was the product of fear and hypocrisy, and only the exceptional few were good throughout. This attitude was strengthened by an innate optimism which made him unduly disappointed when closer contact revealed imperfections in his friends or acquaintances. It also was related to a very surprising feature in Freud — that he was a notoriously poor judge of men. His estimate of them tended to be black or white despite his intellectual knowledge of their complex grayness. Freud had many good personal friends, both those associated with his work and others. But not all of the former were able to face the conclusions that follow from deep psychoanalytic investigation. Three or four of those near to him, on whom he had counted a good deal, turned away and repudiated the conclusions they had previously accepted and expounded. They were then able to enjoy successful careers on the basis of rejecting Freud's sexual theories, and the general public welcomed them with a sense of relief at being rescued from Freud's displeasing ideas. Such events were inevitably a source of deep disappointment to Freud but it would be untrue to say that they caused him any serious distress. *Ernest Jones, M.D. Freud and his Achievements. Brit. M. J. May* 5, 1956.

# CASE REPORTS

# Pericardial Cysts: Report of Three Cases

LEOPOLD R. DE ALVARE, M. D., CHICAGO

PERICARDIAL cysts form a small but interesting group among the many varieties of mediastinal cysts. Review of the literature reveals 54 reported cases of this type of cyst. The purpose of this paper is to report three additional cases and briefly review some aspects of the subject.

## TYPE DIAGNOSIS

Since pericardial cysts are almost invariably completely symptomless, they usually are discovered as an incidental finding during X-ray examination of the chest. The vague, nonspecific symptoms that prompted radiological examinations in cases 1 and 3 had no relationship to the actual condition.

Physical examination is likely to be negative, even after the position of the cyst has been discovered by X-ray examination. This is due to the central location in or adjacent to the mediastinum.

Roentgenological examination of the chest by fluoroscopy and by posteroanterior and lateral films of the chest is essential for the localization of these cysts. They appear as a sharply circumscribed, round, or oval radiopaque masses. The cysts generally are anterior in location within the mediastinum[4], frequently lying in the cardiophrenic angle.

Occasionally the cysts occur higher in the mediastinum as in Case 3 and as reported by others[13,26]. Proof of attachment to the pericardial saxe might be gained by observation of movement of the mass with each heart beat, or by diagnostic pneumothorax as has been mentioned[8,12].

Differential diagnosis must include all of the mediastinal cysts, such as teratoma (dermoid), bronchial cysts, duplications of the gastrointestinal tract, and cystic hygroma. Solid tumors of the mediastinum may be confused with these cysts such as lipoma, fibroma, thymoma, and lymphoma. Tumors originating from the anterior chest wall (chondroma) might give a similar picture. Primary tumors of the lung or pleura arising adjacent to the cardiophrenic angle must be considered, and care must be taken to rule out primary neoplasms elsewhere that might metastasize to this region.

## TREATMENT

As with any unexplained mass elsewhere in the human body, accurate diagnosis usually requires exploration and microscopic study of the lesions directly. We might presume that surgery might be withheld because of lack of symptoms and apparent good health of the patients and because of the predilection of benign tumors for the cardiophrenic angle. This would be an unfortunate choice since not only would the doctor and patient be plagued with the worry of uncertainty but an otherwise curable malignancy might be overlooked.

Thoracotomy would always be indicated unless examinations revealed a mass to be a com-

*Grant Hospital Department of Surgery*

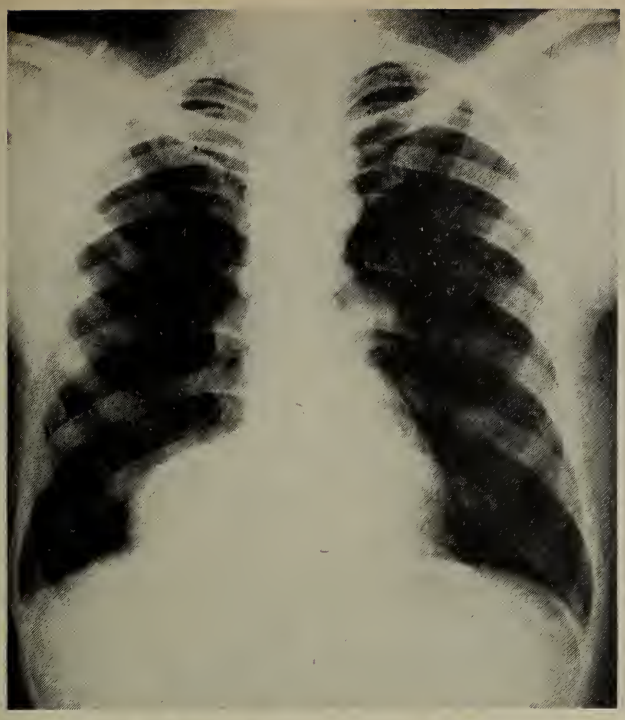


Figure 1—Posterior-anterior X-ray examination of the chest in Case 1 shows a rounded, radiopaque shadow at the right cardiophrenic angle.

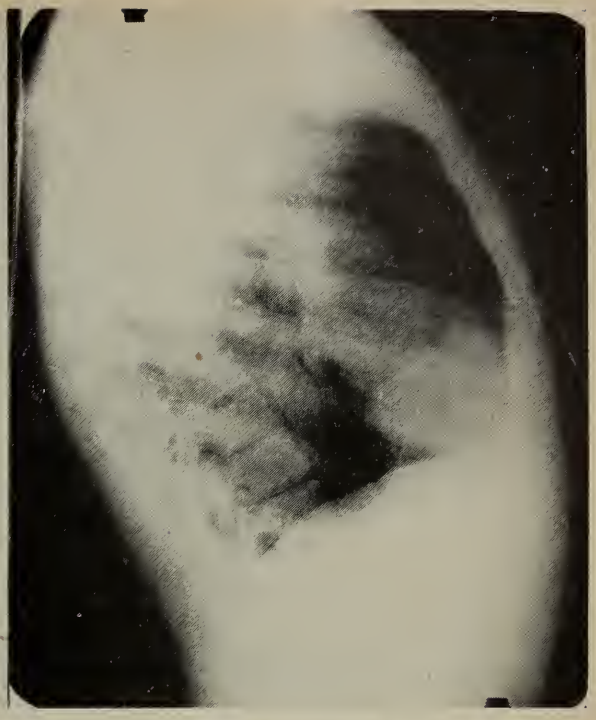


Figure 2—Lateral X-ray picture locates the mass in the anterior mediastinum.

ponent of a widespread process where surgery would be inadvisable[28].

The gross appearance of the cyst is so typical, there usually is little question as to the diagnosis at surgery. Complete removal of the cyst wall is necessary to prevent it from reforming.

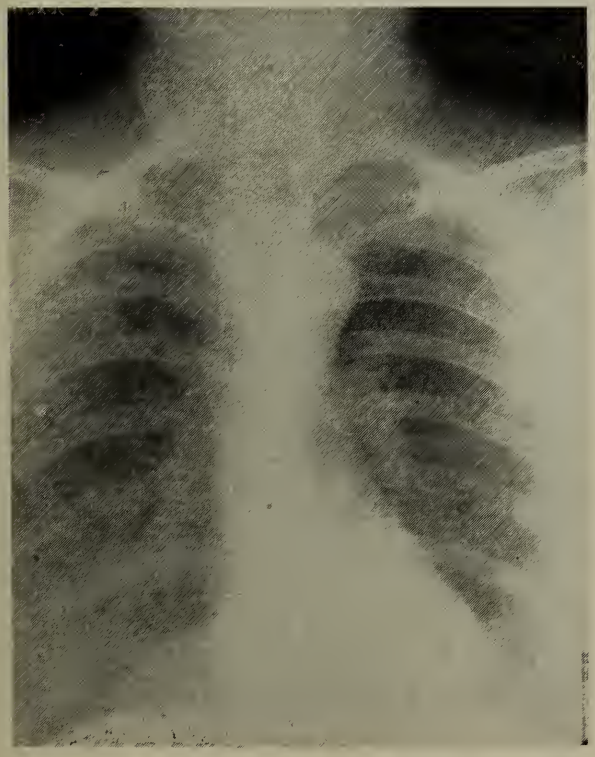


Figure 3—Posterior-anterior X-ray film of the chest in Case 2 shows a small mass in the right cardiophrenic angle.

## PATHOLOGY

A pericardial cyst is typically a solitary, unilocular cyst with a thin translucent wall often giving it a bluish appearance. The content is always a crystal clear, colorless, watery fluid. It sometimes is attached by a pedicle (Figure 4). Most commonly it is located at the right cardiophrenic angle (Figures 1 and 3) but may be



Figure 4—Operating room photograph of the cyst in Case 2. Cut end of the 6th costal cartilage is seen at the right. The pericardium is behind the cyst and the cyst rests on the diaphragm with its stalk indicated by the hemostat at the cardiophrenic angle.

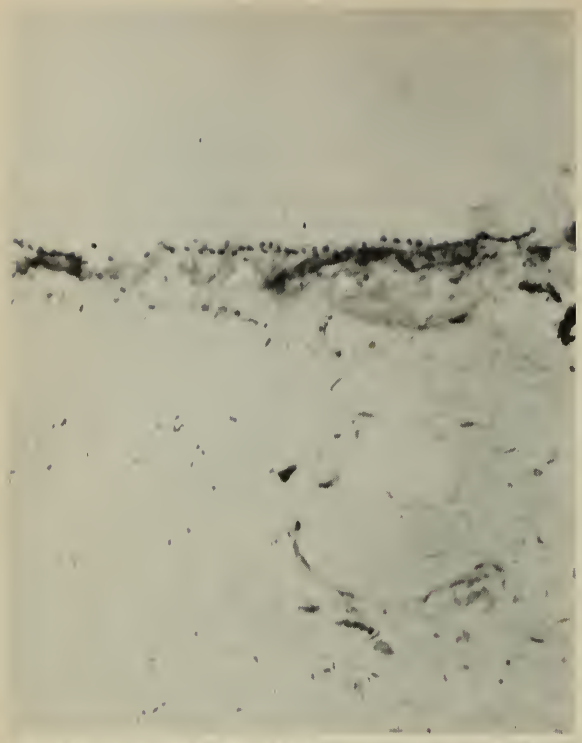


Figure 5—Microscopic section in Case 2. A single layer of flattened cells line the cyst. The stroma is made up of loose areolar tissue.

located at the left cardiophrenic angle or higher in the anterior mediastinum (Figures 6 and 7.). Microscopically, the wall (Figure 5) consists of loose fibrous tissue lined by a single layer of flattened epithelial cells. The nature of the lining membrane differentiates the various types of cysts such as bronchial and dermoid.

## PATHOGENESIS

Most of the theories explaining the occurrence of these cysts are based on embryological development. No single theory has been universally accepted, but each will be mentioned.

1. Mesenchymal lacunae in the mediastinum may persist and grow into an isolated cyst.[24]
2. Cysts located at the anterior cardiophrenic angle might be due to a persistence of the pericardiat recess.[26]
3. Another theory suggests their formation at a later stage[12,20]. In the 15 mm. embryo the primitive pleural cavity forms and extends ventrally between the mesoderm of the pericardial cavity and the ectoderm of the primitive thoracic wall. Unequal growth



Figure 6—Posterior—anterior X-ray examination of the chest in Case 3 shows the circumscribed mass extending outward from the upper right heart border.



Figure 7—Lateral view of the chest in Case 3 locates the rounded mass in the anterior mediastinum.

rates might produce abnormal folds and give rise to mesothelial cysts.

4. The persistence of an infracardiac bursa also has been suggested as a possible origin[29], though this would explain the cyst on the basis of a subdiaphragmatic defect.

Case No. 1: J. W., a 34 year old, colored male, was admitted to St. Francis Hospital, Peoria, December 4, 1950.* Symptoms consistent with an occasional asthmatic attack and palpitation prompted X-ray studies of the chest in 1949. At that time a mass was noted in the right cardiophrenic angle. Physical examination revealed nothing abnormal. Roentgenograms on admission (Figures 1 & 2) revealed that the mass had increased in size.

Under cyclopropane endotracheal anesthesia, the right pleural cavity was entered through the bed of the 8th rib. A large cyst was found lying in the anterior chest at the cardiophrenic angle and extending anteriorly to the pericardium to which it was adherent. The cyst was thin walled and contained clear, colorless fluid. The entire cyst was removed and the chest was closed with catheter drainage. Recovery was uneventful and the patient was discharged on the 10th postoperative day.

Pathological examination reported a 7.5 x 3 cm. cyst whose wall was formed by a delicate membrane which was almost transparent in several areas. The cavity appeared to be somewhat loculated. Microscopic sections showed that the cyst cavity was lined by a single layer of flattened epithelial cells. The remainder of the wall was made up of loose areolar tissue only .

Case No. 2: M. S., a 62 year old, white female, was admitted to Grant Hospital, Chicago, September 26, 1950.** She had no symptoms, but X-ray examination done by a mobile unit at a county fair reported a mass in the right lower lung field. Physical examination was noncontributory and an electrocardiogram write out was normal. Roentgenograms of the chest showed the round shadow near the right cardiophrenic angle anteriorly (Figure 3).

Under ether endotracheal anesthesia, the right chest was opened through a small anterior incision in the sixth intercostal space. A lime sized, thin walled cyst was found attached to the cardiophrenic angle by an inch long narrow stalk (Figure 4). It contained crystal clear fluid. The stalk was transfixed and ligated and the cyst removed. The chest was closed with drainage. The postoperative course was uneventful, the patient leaving the hospital on the 11th postoperative day.

Pathological examination reported a 7.5 x 3 cm. cyst whose wall was formed by a delicate wall. The inner surface was smooth and glistening. Microscopic sections showed the cyst wall consisted of a single layer of flattened epithelial cells with scanty stroma (Figure 5). Beneath this was areolar tissue with some areas containing dense collagen tissue.

Case No. 3: I. R., a 48 year old, white female was admitted to Grant Hospital, Chicago, September 17, 1952.* Because of vague complaints of weakness, tiredness, and slight chest pain. X-ray examination of the chest had been done and showed a mediastinal mass. Physical examination was normal except for a blood pressure of 180/95. Bronchoscopy revealed no abnormalities. Roentgenograms of the chest revealed a large mass in the upper anterior mediastinum extending into the right pleural cavity (Figures 6 & 7).

Under ether-oxygen endotracheal anesthesia, the right pleural cavity was entered through the bed of the fourth rib. A cystic mass approximately 8 cm. in diameter was lying in the superior anterior mediastinum. It contained several hundred cc. of watery clear fluid. The cyst bulged laterally, angulating the superior vena cava and pushing the phrenic nerve anteriorly. A small portion extended behind the vena cava just superior to the azygos vein. The entire cyst was removed and the chest closed, using catheter drainage. Recovery was uneventful and the patient was discharged from the hospital on the eighth postoperative day.

Pathological examination reported a cyst wall, measuring 7 cm. x 15 cm. with a gray, translucent appearance. The inner surface was smooth and glistening. Microscopic sections revealed the wall was composed of areolar and collagen connective tissue with many small blood vessels. The only remnant of an inner layer were scattered collections of flattened cells, presumably of mesothelial origin.

*from the Surgical Service of Dr. Charles D. Branch

**from the Surgical Service of Dr. William L. Riker

*from the Surgical Service of Dr. Hiram T. Langston.

SUMMARY

1. Three new cases of pericardial cysts are presented.
2. They represent examples of the different varieties: topographical or anatomical (low and high mediastinal; with and without pedicle).
3. The pathology, diagnosis, pathogenesis, and treatment are discussed.

The author would like to express his appreciation to Dr. Wm. L. Riker, Dr. Hiram T. Langston, and Dr. Chas. D. Branch for their co-operation and help in preparing this article.

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## Total medicine, 300 B.C.

After Silenus had helped himself to some cheese before bedtime, he awoke the next day with painful indigestion. But Proclops, his friend, who had eaten an equal portion, suffered no ill effects. Since the cheese had affected each man in a different way, Hippocrates reasoned that Silenus, the man, was sick and not Silenus' stomach. As it happened, Silenus had spent a strenuous day at the gymnasium. He was tired and overheated when he ate the cheese. Thus, a surplus of "fire" had upset his humoral balance. To correct this Hippocrates advised Silenus to avoid strenuous exercises or to cool off before eating. If he did not, serious trouble might ensue. Hippocrates knew that the course of any disease was determined to a great extent, by the patient's environment and way of life. He knew further that a discordant organ could upset the whole person. "To heal even an eye," he contended, "one must heal the head and indeed the whole body." *Otto L. Bettmann's A Pictorial History of Medicine.*

# Guillain-Barre Syndrome in Children

John J. Marino, M.D.,* Salvatore Motto, M.D.,† and John C. Przypyszny, M.D.,† Chicago

THERE has been little recorded in the literature concerning the use of 2, 3 dimercaptopropane (BAL) in the treatment of Guillain-Barre syndrome in children; therefore, a case report of an 8 year old boy is presented. A brief review of the domestic and foreign literature of this syndrome in children emphasizes the fact that this syndrome is being seen more frequently in pediatrics.

In 1916, Guillain, Barre, and Strohl[1] described a neurological syndrome which was found among the Allied troops in France. This syndrome was characterized by three major findings: symmetrical flaccid weakness with little or no sensory manifestations; spinal fluid findings of elevated protein with little or no rise in cells (cyto-albuminose dissociation); and complete recovery. It had been Guillain's belief that this syndrome affected individuals between the ages of 20 and 50, and was seen rarely in the younger and older age groups. However, evidence is accumulating in the medical literature which reveals that this symptom-complex is much more common in children than Guillain had originally believed.

Fitzgerald and Wood[2] have stated that 25% of the cases occur before 20 years of age. Casamajor and Alpert[3] reported 22 cases in children; nine were under age 5 and four were 2 years of age. In a series of 16 cases, Roseman and Aring[4] reported four in children. Howard and Friedman[5] reported that the general pediatric hospital has an approximate incidence of one case of Guillain-Barre syndrome in 5,000 admissions. Review of the foreign literature between 1942 and 1952 reveals frequent case reports of this syndrome in children.[6,7,8,9,10,11] The syndrome has been reported following mumps, scarlet fever, chicken pox, measles, and smallpox vaccination.[12,13,14]

Baker[15] has reported there is no predilection for either sex. He noted that the disease tends to appear mainly in the winter and summer months, although cases are known to occur throughout the year. In his series, the youngest child affected with this syndrome was 1½ years of age.

The classical symptoms in children do not seem to differ from those in adults. The onset usually is preceded several days or weeks by an upper respiratory infection. Mild headache and vague pains in the back and the legs are the first complaints. The first neurological manifestations may be paresthesias, usually of the lower extremities. However, motor involvement gradually presents itself, and once it does, the sensory changes are rapidly over-shadowed. Motor involvement is bilateral and fairly symmetrical, changes are rapidly overshadowed. Motor in-Motor involvement ascends to the arms and may even affect the facial nerves, causing facial paralysis. Cord involvement in children is rare, and adults are more prone to have the facial paralysis.[16] The reflexes, superficial and deep, are diminished and in many cases completely absent. The temperature remains normal or may be slightly elevated.

The most important differential aid in this syndrome, is the spinal fluid analysis. Guillain, in his original work, described the occurrence of an elevated protein and a normal cell count. Serial spinal fluid examinations may be necessary before the typical cyto-albuminose disproportion appears. In Haymaker and Kornohan's[17] series of 50 cases, 12 cases did not show elevation in the spinal fluid protein.

Regarding the pathological findings, most investigators have found nonspecific degenerative changes in the nerve root and peripheral nerves, with secondary changes involving the spinal cord. There is little pathological material for analysis due to the low mortality in children.[18,19]

The prognosis, according to Guillain, was good and he believed all those afflicted with the syn-

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drome recovered. In 1937, however, he revoked his opinion without reservation.[20] Most of the deaths are due to respiratory failure, when the bulbar portion of the brain is affected. Since involvement of the bulbar area is rare in children, their prognosis is better than that of the adults. The rate of recovery varies from several weeks to years, and the reflexes may remain absent for many years after full motor power has been regained.[21]

The main diagnostic problem in children is that of differentiating the Guillain-Barre syndrome from anterior poliomyelitis, postdiphtheric neuritis, lead intoxication, and secondary neuritities. Anterior poliomyelitis is characterized by a febrile onset and asymmetrical and localized involvement of the extremities, whereas the Guillain-Barre syndrome usually has an afebrile course and the involvement of the limbs is symmetrical. The findings of the spinal fluid should be of great assistance.

The diagnosis of postdiphtheric peripheral neuritis should be aided by the history of a previous diphtheric infection. In this neuritity, a cyto-albuminose disproportion may be seen. Lead intoxication should be differentiated by means of the history of exposure and by the blood findings. Secondary polyneuritis due to infections and toxins should be differentiated by history and negative spinal fluid findings.

Treatment varies since the etiological agent is unknown. General belief is that it is due to a neurotrophic virus and the accepted therapy is supportive, with ample vitamin supplementation, thiamin HCL 50-100 gm./day, liver extract, bed rest, and physiotherapy. Tracheotomy and/or use of artificial respirators are indicated in severe respiratory embarrassment. Furmanski,[22] after treating four cases with 2, 3 dimercaptopropane (BAL) in which three recovered and one improved, suggests a daily dose of 1.5 mg./kg. of BAL as the clinical picture indicates. Von Hagen and Baker[20] recommend 2.5 mg./kg. of BAL every six hours for at least four to six days in moderately severe cases. They had favorable results in treating 14 out of 15 cases with this dosage. The use of ACTH has been recommended but its merits are still undetermined.[23,24,25]

R.C., an 8 year old male child, was well until one week prior to hospitalization, when he showed symptoms of a mild upper respiratory infection without fever. He became progressively anorexic and lethargic, and complained of pain in his lower legs and generalized weakness. He became ataxic, walking with a wide gait, and complained of nuchal rigidity.

On admission, the child was ataxic and weak. He was unable to lift himself out of the bed without difficulty and assumed the "tripod" position when sitting. Physical examination revealed a temperature of 99, pulse 55, and respirations 16. E.E.N.T. examination revealed only an injected throat. Heart, lungs and abdomen were negative. Neurologically, there was some nuchal rigidity. The spine sign for rigidity and Kernig's sign were positive. The deep tendon reflexes were diminished in the lower extremities. There was weakness and paresthesias of the legs. The spinal fluid examination, at this time, revealed 73 mgm. protein, no cells, 80 mgm. sugar, and 440 mg. chlorides. The Pandy was 4 plus.

The blood picture was as follows: RBC 4.11 million, Hb. 81% - 12.5 gm., C.I. 0.9, WBC 7,200, 60% neutr. segs., 3% neutro. stabs, 3% lymphocytes.

The urine was as follows: Sp.Gr. 1.005, pH 7.0, albumin - 0, sugar - 0, acetone - 0, few epithelial cells.

Diagnosis of Guillain-Barre syndrome was made, and the child was placed on 100 mgm. thiamin HCl/day, 1.5 units of liver extract, 300 mgm. Terramycin®/day, and an oral multivitamin preparation.

The child remained afebrile. The second day after admission, he developed a rasping voice and had difficulty swallowing. Due to the latter, intravenous fluids were given. The superficial reflexes disappeared by the third day. A repeat spinal fluid at this time showed 190 mgms. protein with three cells. The sugar was 96 mgm. and the chlorides, 800.

On the fourth day, the child suddenly developed respiratory difficulty, with some subcostal, intercostal, and supraclavicular retractions. By means of postural drainage, copious amounts of mucoid phlegm were obtained. At this time, a diminished gag reflex was noted. The boy continued to have respiratory difficulty throughout the day, but with the aid of an aspirator and postural drainage, was kept comfortable. The chest remained clear throughout the episodes of respiratory embarrassment.

The child after the fourth day began to show faint signs of improvement. The swallowing reflexes improved so that intravenous therapy was discontinued. The voice retained its rasping quality. The reflexes persisted in their absence, and the child continued ataxic.

On the eighth day, all medication was stopped, and the child was placed on 1.5 mgm./kg. of 2.3 dimercaptopropane (BAL) according to Furmanski's recommendation. He received 37 mgm. of BAL daily. He gradually began to show improvement in strength by beginning to sit up with less difficulty; the voice became huskier; and, subjectively, the child felt much better and began to eat with more desire. He was continued on this dosage of BAL for ten days, during which time he was strong enough to use the walker twice a day for about 10 to 15 minutes. He walked by himself for ten feet, but maintained a spastic and ataxic gait. By the 16th day, the cremasteric reflexes began to return, and each day became more active.

On the 18th day, the dosage was increased to 2.5 mgm./kg. for a total daily dosage of 55 mgm. He was kept on this for three days, when he was discharged. The child received in the hospital a total of 530 mgm. of BAL without untoward effects.

After six months of supportive therapy at home, the child had regained full motor power in his extremities. All reflexes were present. There were no paresthesias or signs of ataxia, and the cranial nerves were intact. The voice was of normal quality. The child has no difficulty in competing in activities with other children. No residual signs of his disease can be detected.

## SUMMARY

A brief review of the foreign and the domestic literature of the Guillain-Barre syndrome in children is presented. A report of an 8 year old boy, who was afflicted with this syndrome-complex, and treated with 2.3 dimercaptopropane (BAL), is discussed. BAL therapy did the patient no harm; however, how much beneficial result was obtained with its use is difficult to evaluate in this one instance.

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# EDITORIALS

## John Evans

John Evans was one of the great physicians of the 19th century. He was born in Waynesville, Ohio, in 1814 and was graduated from Lynn Medical College, Cincinnati, in 1838. Dr. Evans practiced medicine in the wilds of Indiana for six years, where his friendship with Abraham Lincoln started. In 1848 he settled in Chicago and later became Governor of the Territory of Colorado.

Evans left his mark wherever he lived and was rewarded by having a city in Illinois named for him (Evanston) as well as one of the highest peaks in the Rockies (Mt. Evans) and a business block and public school in Denver. This physician erected the first hospital for the insane in Indiana and was co-founder of the American Medical Association, the Chicago Medical Society, and the Illinois State Medical Society. He was one of the organizers of the Hospital of the Lakes, which later became Mercy Hospital. In addition, he founded the first high school in Chicago and inaugurated its present educational system. Evans was active in establishing Northwestern University and became the first president of its Board of Trustees.

This superman opened mines and started many towns in Colorado, installed street cars in Denver, and founded Denver University and became president of its Board of Trustees. His interests extended also to railroads; he raised funds to build the Chicago-Ft.Wayne Railroad which later became part of the great Pennsylvania system; and the railroad he built from Cheyenne to Denver now is part of the Union Pacific. All these accomplishments took place while Dr. Evans was an active practitioner of medicine and a professor of obstetrics. He gave $180,000 to Northwestern University and $150,000 to Denver University.

The members of the Illinois State Medical Society are proud of their founder. We need more men of medicine who are willing to give their time and money to worthy projects in which they believe.

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## Verbal surgery for medical ethics

Final action on a drastic revision in the wording of the Principles of Medical Ethics is to be taken at the American Medical Association's Clinical Session in Seattle Nov. 27-30.

The House of Delegates, at the American Medical Association's June meeting in Chicago, voted in favor of the proposed revision and approved the delay in final action "to allow ample opportunity for thorough study on the part of members of the American Medical Association." The Principles as proposed consist of a brief Preamble and 10 sections which succinctly express the fundamental ethical concepts embodied in the present code.

Here is the tentative wording of the 10 sections:

"1. The prime objective of the medical profession is to render service to humanity with full respect for both the dignity of man and the rights of patients. Physicians must merit the confidence of those entrusted to their care,

rendering to each a full measure of service and devotion.

"2. Physicians should strive to improve medical knowledge and skill, and should make available the benefits of their professional attainments.

"3. A physician should not base his practice on an exclusive dogma or a sectarian system, nor should be associate voluntarily with those who indulge in such practices.

"4. The medical profession must be safeguarded against members deficient in moral character and professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

"5. Except in emergencies, a physician may choose whom he will serve. Having undertaken the care of a patient, the physician may not neglect him. Unless he has been discharged, he may discontinue his services only after having given adequate notice. He should not solicit patients.

"6. A physician should not dispose of his services under terms or conditions which will interfere with or impair the free and complete exercise of his independent medical judgment and skill or cause deterioration of the quality of medical care.

"7. In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him to his patient.

"8. A physician should seek consultation in doubtful or difficult cases, upon request or when it appears that the quality of medical service may be enhanced thereby.

"9. Confidences entrusted to physicians or deficiencies observed in the disposition or character of patients, during the course of medical attendance, should not be revealed except as required by law or unless it becomes necessary in order to protect the health and welfare of the individual or the community.

"10. The responsibilities of the physician extend not only to the individual but also to society and demand his co-operation and participation in activities which have as their objective the improvement of the health and welfare of the individual and the community."

There is the proposed new language of the Principles of Medical Ethics and now is your chance to express your opinions before a final vote is taken.

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## The annual AMA meeting in Chicago

The 105th Annual Meeting of the American Medical Association was held in Chicago June 11-15. The Illinois State Medical Society and the Chicago Medical Society were official hosts for the meeting. The large array of scientific and technical exhibits were shown at the Navy Pier, while the dozens of scientific meetings were held at the Pier, the University of Illinois buildings, and nearby hotels and auditoriums.

The dinner for delegates to the AMA, officers and distinguished guests, was presented in the new Prudential Building, with the host societies responsible for the arrangements. The Illinois State Medical Society had its official headquarters in the Palmer House, where many hundreds of guests were received during the meeting. The slogan "The Land of Lincoln" was adopted for this occasion and some unusual features for the entertainment of the new guests were developed.

A fine array of oil paintings of scenes at New Salem in Lincoln's days were presented, these being loaned for the occasion and brought to Chicago and installed by representatives of the Illinois Department of Public Health. Bronze busts of Lincoln were presented to many visitors with the compliments of the Illinois State Medical Society. The State of Illinois sent thousands of pamphlets of the Illinois state parks, and historic sites in this state, which were of interest to the hundreds of visitors.

The meetings of the House of Delegates were held in the Grand Ballroom at the Palmer House, and all but one member of the entire House membership responded to the roll calls for the meetings. As usual, the many reports, resolutions etc. were referred to reference committees and any member of the AMA was permitted to attend these hearings and participate in the deliberations.

Another new feature sponsored by the Illinois State Medical Society was added this year when the State Society acted as host for an

evening of entertainment at the Hotel Sherman for alternate delegates to thee AMA from the various states and territorial possessions. The meetings of the House of Delegates were of unusual interest and many important actions were taken. These will soon appear in the Journal of the American Medical Association and should be of interest to physicians everywhere.

Many compliments were received during and after the meeting from delegates and other members of the AMA who appreciated the efforts of the host societies in the endeavor to assure them they are always welcome in Illinois.

The next annual meeting of the AMA scheduled for Chicago will be in 1960, at which time we hope to have the new convention hall operating on the lake front which we believe is to be the largest convention hall in the nation.

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## Communicable disease control*

Because of the high rate of poliomyelitis this early in 1956, all physicians are urged to continue to vaccinate as many children as possible.

This is the recommendation of the Illinois Department of Public Health Poliomyelitis Technical Advisory Committee, after reviewing the situation that now exists in Chicago, at a meeting July 9, 1956.

1. The proportion of paralytic cases is high and spinal paralytic cases are especially high.

2. The proportion of bulbar cases is low.

3. Children under 5 years of age have a higher incidence than usual. (This largely represents an unvaccinated group.)

4. There is no satisfactory evidence that poliomyelitis vaccine is responsible for the high incidence of polio in Chicago.

5. The Committee will continue to study the situation and unless you are advised to the contrary, inoculations of poliomyelitis vaccine should continue.

The Committee, however, also recommends that the vaccine should not be given to household contacts of an acute poliomyelitis case.

6. The Committee has requested that the Illinois Department of Public Health make every effort to obtain from every case an acute phase stool and blood specimen and a convalescent phase blood specimen and submit them to the Virus Research Section of the Illinois Department of Public Health Laboratory, 1800 W. Fillmore Street, Chicago, for virus isolation and antibody titration.

Physicians are urged to co-operate in obtaining these specimens.

The following statement was released to the press:

"The Poliomyelitis Technical Advisory Committee of the Illinois Department of Public Health has reviewed in detail the data submitted by the Chicago Board of Health and recommends that poliomyelitis vaccinations be continued."

*Illinois Department of Public Health

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## Keeping up to date by reading

> That early and invincible love of reading which I would not exchange for the treasures of India.
>
> Edward Gibbon

As the historian Gibbon remarked years ago, every man has two educations, one given him by his teachers and the other, the more important, given him by himself. Every physician knows of the tremendous advances made in all branches of medicine in this century, realizes that the expansion is still going on rapidly, and appreciates the difficulty of keeping up to date. One very important source of information is the printed page, and most physicians read articles in medical books and medical journals, some of them in the form of abstracts. Recently Ralph M. Besse, a business executive, published an informative and thoughtful article on the philosophy of reading.* He states that if you read every day for just fifteen minutes, at an average rate of 300 words a minute, you will read a million and a half words a year, or an average of 20 books. He points out that William Osler did just about that for he read for 20 minutes a day, though he may have gone over that limit at times.

Mr. Besse indicates in his article certain procedures which help the reader. A desire for reading, especially about things that you are responsible for and get credit for doing, must be established. Many physicians have already contracted such a desire as medical students and are particularly interested in all advances bearing on their field of activity either as general practitioners or specialists. It is desirable to schedule your time, but this is more difficult for

*Besse, Ralph M. The Freeman, Jan. 1956. Published by the Foundation for Economic Education. Irvington-on-Hudson.

doctors than for members of any other profession because of unpredictable emergencies. As a matter of fact you can read almost any time and any place, even in the bathroom, when you have a few spare minutes. Mr. Besse advises reading more than one book at a time because moods and degrees of fatigue vary. When you are fresh you can read the more serious or technical literature and when tired the lighter material. Aside from information that you pick up at medical meetings and by informal chats with others, you learn from experience and by thinking things out yourself. But, after all, publications of various kinds are the most complete, the most available, the cheapest and the quickest sources of new knowledge. So, as Mr. Besse suggests, try to read only the best books and articles, don't hesitate to reread them if you think it desirable, don't necessarily read entire books, and learn to evaluate what you read by reflection and analysis.

G. B.

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## Hospital accreditation

Hospital accreditation was one of the major subjects acted upon by the House of Delegates at the 105th annual meeting of the American Medical Association. The Committee to Review the Functions of this Commission came to the following conclusions:

"1. Accreditation of hospitals should be continued.

"2. The Joint Commission should maintain its present organizational representation.

"3. The Board of Trustees should report annually to the House of Delegates on the activities of the Joint Commission.

"4. Physicians should be on the administrative bodies of hospitals.

"5. General practice sections in hospitals should be encouraged.

"6. Staff meetings required by the Joint Commission are acceptable, but attendance requirements should be set up locally and not by the Commission.

"7. The Joint Commission should not concern itself with the number of hospital staffs to which a physician may belong.

"8. The Joint Commission is not and should not be punitive.

"9. The Joint Commission should publicize the method of appeal to hospitals that fail to receive accreditation.

"10. Reports on surveys should be sent to both administrator and chief of staff of hospital.

"11. Surveyors should be directly employed and supervised by the Joint Commission.

"12. Surveyors should work with both administrator and staff.

"13. New surveyors should receive better indoctrination.

"14. Blue Cross and other associations should be requested not to suspend full benefits to nonaccredited hospitals until those so requesting have been inspected.

"15. The American Medical Association should conduct an educational campaign for doctors relative to the functions and operations of the Joint Commission.

"16. The Committee also suggests that the American Medical Association and the American Hospital Association encourage educational meetings for hospital boards of trustees and administrators either on state or national levels to acquaint these bodies with the functions of accreditation.

"17. This Committee asks to be discharged upon submission of this report to the House of Delegates."

The House also approved a reference committee suggestion that the following statement be added to strengthen the report:

"The Committee recommends that the commissioners to the Joint Commission on Accreditation of Hospitals, appointed by the Board of Trustees of the American Medical Association, urge that Commission to study:

"1. The problems of the exclusion from hospitals and arbitrary limitation of the hospital privileges of the general practitioner, and

"2. Methods whereby the following stated principles may be achieved:

" 'The privileges of each member of the medical staff shall be determined on the basis of professional qualifications and demonstrated ability.'

" 'Personnel of each service or department shall be qualified by training and demonstrated competence, and shall be granted privileges commensurate with their individual abilities.' "

## I.S.M.S. donation to the A.M.E.F.

At the first session of the AMA House of Delegates at the annual meeting held in Chicago June 11-15, F. Lee Stone, President and Harold M. Camp, Secretary of the Illinois State Medical Society, presented to the American Medical Education Foundation a check for $164,940, which represented the amount allocated from the dues paid by each member as received up to June 1, 1956.

Dr. Louis H. Bauer, President of the A.M.E.F., received the check and stated that this was the largest which had been received from any state society since the Foundation was organized. In a period of less than four years the Illinois State Medical Society has given the Foundation nearly $700,000 from the allocation of a portion of the dues of paying members of this Society.

Doctor Bauer was grateful for this donation from Illinois physicians. He stated that in addition to the amount allocated from annual dues in Illinois, many thousands of dollars were received annually by the A.M.E.F. from members of the Illinois State Medical Society who were anxious to help the cause of medical education.

Illinois was the first state to establish the so-called "Illinois Plan" whereby a portion of each physician's dues was allocated to medical education. Since this initial action was taken by our House of Delegates some four years ago, the idea has been spreading slowly throughout the country and more and more state societies are taking similar action.

It has been the consensus of our House of Delegates that this is an equitable and fair way in which to aid the cause of medical education, and a democratic means whereby funds may be made available to our medical schools to be used as each school desires.

It will be interesting to watch future action on the part of other state medical societies, and it is to be hoped that many more of them will follow this plan to provide needed funds for the "doctors of tomorrow".

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## Arsenic in tobacco

The arsenic content of American tobacco cigarettes increased in 20 years from an average of 12.6 microgram per cigarette in 1932 to 42 in 1950-51 — more than 300 per cent. During this time cigarette production and consumption in the United States rose by 300 per cent. The product of these two factors indicates that nine times more arsenic was distributed in cigarettes and likewise in cigarette smoke, to be inhaled by consumers, at the end of this period than at its beginning. This rise in the arsenic content of cigarette smoke coincided with an increase in the death rate from cancer of the lung of 200 per cent in women and 600 per cent in men. The sequence of events, which presents a challenge to physicians interested in public health, demands scrutiny that does not neglect study of one of the earliest features. Belated attempts at correction (since 1946) by substitution of organic pesticides for arsenicals, however commendable, cannot purify soils of tobacco plantations that have, for many years, been impregnated by residues of a heavy and relatively insoluble poison, arsenate of lead, which will continue to release arsenic in soluble form, which happens to be the only component of tobacco smoke that as yet is definitely known to be carcinogenic for man. *Henry S. Satterlee, M.D. The Problem of Arsenic in American Cigarette Tobacco. New England J. Med. June* 21, 1956.

# Pictorial Report on the 1956 Annual Meeting

**The 116th annual meeting of the Society was held at the Hotel Sherman in Chicago. More than 3,000 doctors, interns, nurses and guests registered for the four day meeting, May 15-18.**

**Elmer Hess, President of the AMA was present throughout the entire meeting, and appeared before the House of Delegates, the Woman's Auxiliary and other groups, in addition to making the main address at the annual dinner.**

**One change from the usual schedule was the buffet supper, with floor show and dancing, presented on Tuesday by the Woman's Auxiliary to the Society. This replaced the Hospitality Hour of former years.**

**If you were unable to attend, herewith a picture story of some of the happenings.**



**At the close of the final session of the House of Delegates, F. Lee Stone (left above) was inducted into the office of the presidency. He brought Mrs. Stone to the rostrum to share the general applause, and they were joined by Lester A. Reavley of Sterling, President-Elect.**



**(Left) The Womans Auxiliary had an unusally successful meeting, with a large and enthusiastic attendance. Mrs. Robert E. Dunlevy, Pekin, is the new President. Mrs. Nicholas G. Chester, Oak Park, became President-Elect.**



**At the opening of the first session of the House of Delegates, F. Garm Norbury, President, presented Elbridge W. Telford, of DeKalb with the Society's certificate for the outstanding "General Practitioner for 1956". Dr. Telford, 54, is one of the youngest of 8 physicians to receive this award from his colleagues in the State.**

# The Annual Dinner



(Above) A partial view of the speakers' table at the annual dinner shows, (from left to right) Arkell M. Vaughn, F. Garm Norbury, Elmer Hess, George F. Lull and Edwin S. Hamilton. Dr. Hess delivered the main address under the title "The Human Side of Medicine".



The unusual picture (above) brings together 4 graduates of Illinois College, Jacksonville; Charles H. Ramelcamp, '33, who delivered the Oration in Medicine; Rev. Fred Hoskins, D.D., '26, Oak Park, who gave the invocation at the annual dinner, and is Chairman of the Board of Trustees, Illinois College; F. Garm Norbury, '12, Secretary of the Board of Trustees of the College, and Brown M. Dobyns, '35, who gave the Oration in Surgery. Both Dr. Dobyns, and Dr. Ramelcamp are from the Western Reserve University, School of Medicine, Cleveland, Ohio.



Dr. and Mrs. Burtis E. Montgomery of Harrisburg arriving for the annual dinner. Dr. Montgomery is a member of the Council, and at the meeting was elected a delegate to the AMA.



F. Lee Stone, our new President, escorts his daughter-in-law, Mrs. Dorothy Stone, and his granddaughter, Dottie Lee Stone, to their table at the annual dinner.

Anyone you know?





## The Woman's Auxiliary Luncheon



At the Woman's Auxiliary luncheon honoring past presidents, the principal speaker was the Hon. Everett N. Dirksen, United States Senator from Illinois. Others (above) are Elmer Hess, Mrs. Warren Young, President, Leo P. A. Sweeney, who introduced the guest speaker and is chairman of the Advisory Committee to the Auxiliary, and Mrs. Matthew Uznanski, President of the Auxiliary to the Chicago Medical Society.



Three who contributed much to the success of the Auxiliary meeting are shown above. They are Mrs. E. H. Leveroos, who was convention chairman, Mrs. Albert Kwedar, a past president, who was chairman of the Past Presidents' luncheon, and Mrs. Henry Bechtold, co-chairman.

## The 50 Year Club Luncheon



As is usually the case, the Fifty Year Club luncheon attracted a large crowd of active and retired members. Shown above, Andy Hall, who continues to head this group and Richard Young, Dean of Northwestern School of Medicine, who gave the principal address. In the foreground, Frank O'Neill, Chicago.



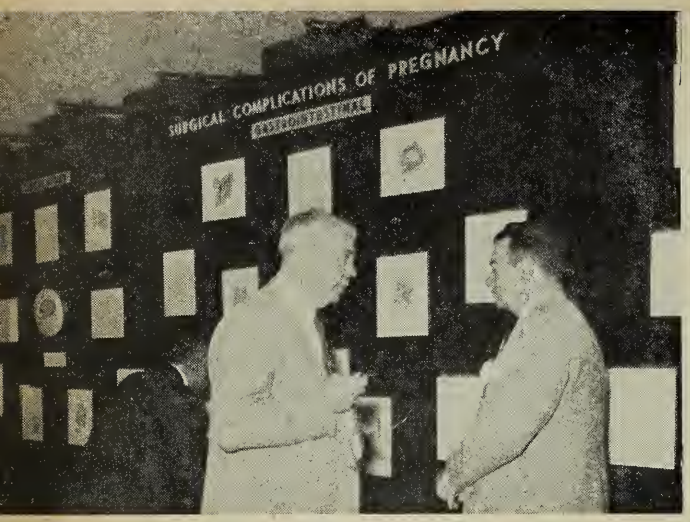
One of the tables at the Fifty Year Club luncheon included the following: George A. Darmer, Aurora, John W. Dreyer, Aurora, Robert L. Van Dellen, Sawyer, Michigan and James L. O'Connor, Chicago. Dr. Van Dellen is the father of the Associate Editor of the Journal.

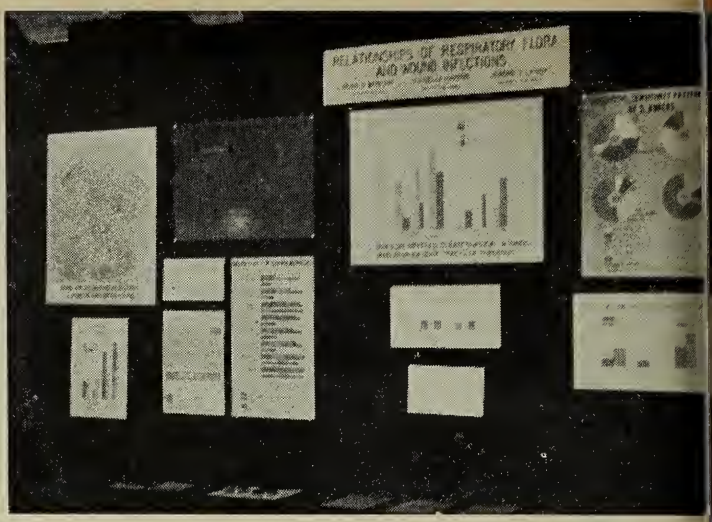


Among other guests and members at the luncheon were Irving I. Neece, Decatur, Hugh McKechnie, J. V. Fowler, Sr., and James H. Hutton, all of Chicago.

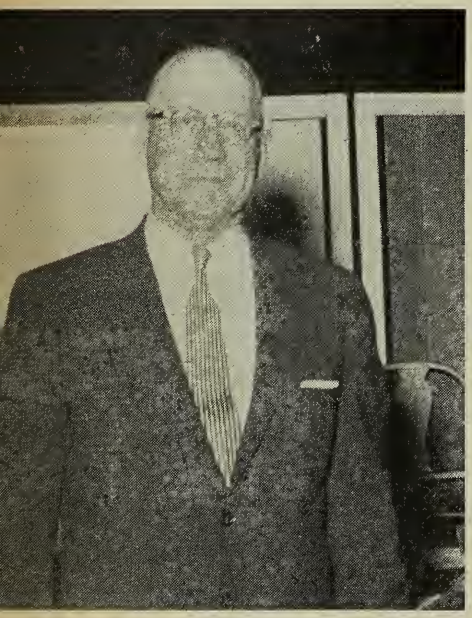


Agnes Mikkelsen, Chicago and A. R. Whitefort of St. Elmo await the start of the proceedings.



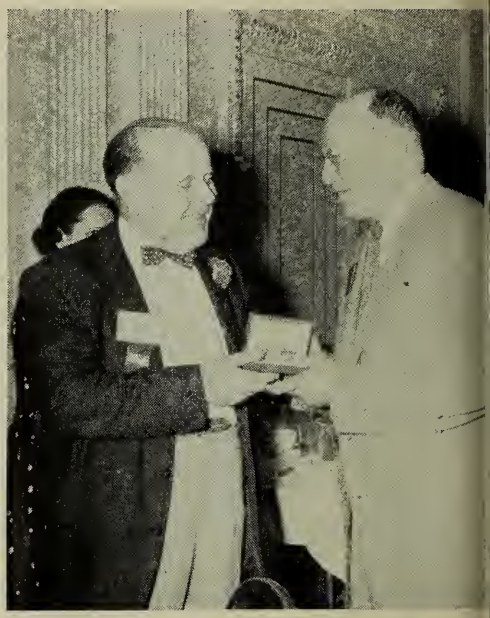




The high quality of the scientific exhibits made judging difficult. (Shown above) are the two gold medal winners. On the left is a view of the exhibit "Surgical Complications of Pregnancy" by Frederick H. Falls and Miss Charlotte S. Holt of the University of Illinois, College of Medicine. On the right is a view of the exhibit prepared by Jerome J. Landy, Isabel Havens and Ross S. Benham of the Universities of Oklahoma and Chicago, titled "Potentially Pathogenic Bacteria Carried in the Respiratory tracts Physicians".



(left) Mr. Ivan E. Parrett, Secretary of the Illinois Agricultural Association's General Services Committee, was given a special award by the Society as the "Individual Deemed to have made the Most Substantial Contribution to the Health Progress of the Citizens of our State". His work in aiding farm youths to obtain medical educations, and his long time interest in improving the health of farm animals as well as humans, earned him the award.

At the final Council luncheon F. Garm Norbury was the pleased recipient of a watch, presented to him by Joseph T. O'Neill on behalf of all members of the Council.








More than 60 exhibitors representing the nation's foremost pharmaceutical and medical supply houses, took all the available display space. They reported good attendance and a high degree of interest in their showing of new additions to the physicians' armamentarium.

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

# Trends in the Practice of Medicine — Part II

Roland R. Cross, Jr., M.D., Chicago

ONE of the main changes that has occurred since World War II has been the development of the health and welfare funds of the various union labor organizations. This has developed as a fringe benefit which labor has negotiated from the employer. The use of the health and welfare fund has been directed in several different ways. Some unions have used such funds for the purchase of standard insurance. Others have directed them toward insurance in which the union itself has a voice in the insurance organization, that is one in which the union itself serves as the insuring body. Another avenue of spending the money has been in the development of clinics or hospitals. The United Mine Workers have spent much money in building hospitals in areas where hospital facilities are scarce, but in areas in which a large group of their members live and work. Other unions, depending upon the size of the income of their health and welfare funds, and upon the size of their member-organization, have developed medical clinics of various types. Some have been purely diagnostic to which a patient could come for laboratory and X-ray procedures which he would ordinarily have to buy on the outside at the direction of his own physician.

Other unions, having a larger membership, and having a larger fund, have developed full-time clinics in which the union member would receive not only diagnostic services, but complete treatment facilities as well. Some of these clinics have developed to where they provide care not only of the union member, but of his dependents. Thus, there has been a wide range of development in the use of health and welfare funds for the benefit of the union member. It is fair to say that the various unions are also somewhat competitive toward each other, and each strives to do a little better service in a slightly different way.

This article is meant to describe a recent visit to the St. Louis Labor Health Institute in St. Louis, Missouri. It recently celebrated the tenth anniversary of existence.

The St. Louis Labor Health Institute was organized by one of the locals of the Teamsters Union in St. Louis. It does not include all of the teamsters nor all of the locals, but only one local of the Teamsters Union in the St. Louis area. This particular local has about 6,500 members. However, the contract calls for the funds of the health and welfare fund to be used for the union member and all of his dependents. Thus, his wife and children and any other legal dependent that the member may have are entitled to care at this clinic. The potential clientele, thus, numbers about 15,000

members. The services include obstetrics, pediatrics, old-age illnesses and dentistry. Approximately 300 patients visit the clinic daily.

The employee contributes nothing to this organization. The cost of operation is paid for by the employer. At present, the employer pays five per cent of the wages of the wage-earner into the health and welfare fund. From this five per cent, the employee and his dependents receive complete medical and hospital care. There are a few exceptions. The patient must buy his own medication. The union clinic has its own drugstore at which the drugs are sold at a small percentage above actual cost. In addition, the union member must pay the actual material cost for such things as dental appliances and prostheses. The union member must also pay the actual cost for such things as eyeglasses. The clinic pays for any ambulance service. The clinic also pays for necessary home calls. The clinic does not pay for hospital care for either tuberculosis or psychiatric disorders.

The St. Louis Labor Health Institute has a Board of Trustees composed of 27 members, all elected by the union members. Of this group, six represent the management, two represent the so-called interested public and 21 represent the union membership itself. All 27 members of the Board of Trustees are nominated by a nominating committee and are then voted upon by the union members.

There is also a Medical Board of Advisors which consists of five outstanding physicians and surgeons in the area. They act in a purely advisory capacity. They may or may not meet at regular intervals. The number of meetings depends more upon the amount of advice which is requested of them. They receive $100.00 per month whether or not their services are used. The Board of Trustees serves without pay.

The clinic itself has a full-time Medical Director and a full-time business manager. The business manager is not a physician. There are also many full-time nurses, technicians and secretaries. The Medical Director examines patients and does so as a part of the Department of Internal Medicine. He not only sees patients in the clinic, but also sees patients at the hospital. In addition to the listed employees, there is the medical staff. At the present time, the medical staff numbers over 50. None of these physicians is full-time. All serve only a part of the time at the union clinic. Otherwise they are engaged in their private practice wherever it may be. It is not the purpose of the union to engage full-time any of these physicians. It is rather the opinion of the union that physicians will have more interest in keeping up-to-date if they are in the active private practice. There will be less tendency toward such physicians to feel that they have a nest from which they cannot be dislodged, and so do not need to maintain their professional training. The physicians are given all of the benefits of the union. They are registered under Social Security. They receive two weeks vacation with pay the first year of employment; they receive three weeks vacation with pay the second year of employment, and, after that, they receive also four weeks sick leave if necessary with pay. They are paid for the seven official holidays each year. The Medical staff has no general practitioners. The medical staff members are either board-certified specialists or are board-eligible. Most of the physicians are on the teaching staff of one or other of the medical schools in St. Louis. The staff is departmentalized rather strictly into the various departments of medicine, surgery, pediatrics, obstetrics. A physician is hired on the basis of how much time he is needed. At the present time, the most time required for the services of any staff physician is one internist who works 19 hours a week. One orthopedic physician works only three hours a week; the other physicians are a group between these extremes. Each department has a chief of the department, and he is paid a small amount over and above the standard wage paid to the other physicians in compensation for the extra work entailed as Chief of the department.

All of the physicians receive an income which has been arranged. It is not based upon the number of patients seen, but upon the number of hours worked per week. Nothing is paid to the general surgeon in the way of an extra amount for surgery on a union member in the hospital. The physicians are paid extra to make house calls at the rate of $6.00 per house call during the daytime; $8.00 for a house call during the evening up until midnight, and $10.00 for a house call at any time during the rest of the night. The union fund also pays for this service. The physicians of the medical staff have a staff meeting once each week for one hour. Roll

is taken at that time to record those in attendance. The physicians are paid a small amount extra for attending these staff meetings. At the staff meeting, all proposed elective surgical procedures are reviewed. No patient is taken to the hospital for elective surgery without his case having been reviewed by the staff prior to the operation. Interesting cases that come to the attention of some member of the staff are also discussed. The separate departments have departmental meetings at regular intervals.

The *pay for the various physicians varies* depending upon the particular department. The pay scale is complicated. Each department negotiates a pay scale with the management of the clinic once each year. The pay scale is based upon the medium income for the group as shown in the survey of the fees and income for various physicians that has been published in Medical Economics. *Roughly* the pay scale for the various physicians is as follows:—a dentist, $10,000 per year; a surgeon $19,000 per year; an internist $15,000 per year; a radiologist $20,000 per year; and the pediatrician $14,000 per year. However, no one physician receives this amount because the rate is based upon the possibility of a 40-hour week, and no physician works a 40-hour week. Accordingly each physician receives that percentage of the above income rate depending upon the number of hours he serves.

The union does not have a hospital to which it is attached. It has no connection with any hospital. It has made no business arrangement with any hospital. Each physician on the staff takes the patient who needs to be hospitalized to his hospital. The hospitals used are those more prominent in the St. Louis area, many of them teaching hospitals connected with the two medical schools. The hospitals that are used are operated on a non-segregated basis. One-third of the union membership are negroes. The main bulk of the patients enter about five of the main hospitals in the St. Louis area; however, there is no rule against a physician taking a patient to any hospital that he chooses. The physician selects the hospital of his choice.

Ten per cent of the money in the health and welfare fund, is set up as a reserve. Twenty per cent of the yearly funds is set aside to cover hospitalization. These union funds are used as their own hospitalization insurance; they do not buy insurance to cover hospitalization from any standard carrier, but rather insure themselves for hospitalization. The remainder of the funds (70%) available operates the clinic. There are about 70 new admissions from the clinic to various hospitals per month. In the year 1955, the clinic hospitalized approximately 2,200 patients. In insuring itself on hospital expenses, the clinic does not guarantee to pay the entire hospital bill. In fact, the clinic pays approximately 80 to 85 per cent of the hospital bill and the patient must pay approximately 10 to 15 per cent. There were approximately 240 obstetrical cases in the year 1955.

The replacement of physicians in the group is small. In only two departments, pediatrics and orthopedics, the turn-over has been rapid. In both, the decision on the part of the physician to stop working at the clinic has been that he has become too busy with his private practice. During the ten-year period of the clinic's existence, two physicians were requested to leave because they couldn't work in a group. Their personalities were too independent for group practice. Other than this, the medical staff has been relatively stable.

All of the members of the medical staff are fully accredited members of the St. Louis County Medical Society. The staff and the clinic does not have a social worker. Such an employee may be required in the future.

Any member of the Teamsters' Union is eligible to receive full medical care for himself and his dependents in the clinic. The clinic will also pay for any medical care and hospitalization which a member or his dependent may need as the result of illness in some other location while on vacation. If a man is laid off from work through no fault of his own, he receives 60 days of eligible medical care if he has been employed for one year, and he receives an additional 30 days for each additional year that he has been employed as a teamster—up to six months. The union is lenient with respect to the rules pertaining to eligibility, and is reluctant to deny a member clinic care. If a union member has been discharged or resigns, he, of course, is immediately dropped from being eligible to receive medical care. However, there is a special provision known as a special member category, wherein a person, who has once been a member

of the union and who has once received medical care from the St. Louis Labor Health Institute, can, if he desires continue in this special-member category, even if he no longer is a member of the union and no longer a teamster. If he comes within the scope of the special-member category, he must pay $12.50 per month, and this covers complete medical and hospital care within the range of services offered by the clinic for him and all of his dependents. The patient-employee is paid while he goes to the clinic, i.e., if he has an appointment at the clinic at 3 o'clock in the afternoon, and at 3 o'clock in the afternoon he is supposed to be at work, he is allowed to go to the clinic and receive full compensation while he is there for the time that he is not at work.

The dental department is a large department and has a busy schedule. In fact, it is one of the busiest departments of the entire clinic.

An entire day was spent visiting the St. Louis Labor Health Institute, which included attendance at one of the staff meetings. The staff meeting was well attended by the members. They took above-average interest in the material presented, when compared to staff meetings of the routine hospital type. The esprit de corps of the medical staff seemed to be exceptionally high. The impression prevailed that (other than there being a difference in the cost of the physical accouterments of the clinic) the work done, the esprit de corps, and the caliber of medical care at the St. Louis Labor Health Institute would compare with any of the country's major clinics, such as the Mayo Clinic and others. The quality of X-rays that were viewed was good. The X-ray and laboratory facilities were adequate. The patients were handled expeditiously and courteously.

All in all, in this particular instance the union has organized a distinctive and beneficial clinic to serve its members and their dependents.

(Trends in the Practice of Medicine — Part I, Illinois M. J. 109: 146 [Mar.] 1956.

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## Freedom for medicine

The Belgian government has surrendered unconditionally to the demands of the medical profession to withdraw its attempt to regulate medical care and medical service under its social security scheme through legislative status. In addition it has agreed to accept the principle of nonintervention through law and to recognize the conventions agreed upon through the joint efforts of representatives of the medical profession and the insurance companies. In September, 1955, the Belgian government instigated legislative measures which would regulate all activities in medical service and medical care. The Belgian doctors, united in their desire to remain a free profession and to protect the rights of the people receiving medical care under the social security plan to receive the best possible medical service available, unanimously opposed the government plan. The united efforts of these doctors has now resulted in an unconditional surrender of the government to the doctors, and recognition by the government of the medical profession's plan to provide good medical care and service to the people. *World Medical Association Release. Indust. Med. April,* 1956.

# THE P. R. PAGE



**Mr. Edward A. Uzemack, Director of Public Relations**

SO that Illinois public relations chairmen can be among the best informed in the nation, the Council has agreed to underwrite their expenses to the American Medical Association's PR Institute, which will be held at Chicago's Drake Hotel August 29 and 30.

The Institute presents an exceptional opportunity to pick up new techniques in medical public relations and to swap ideas with medical PR people from all over the country. Its success is attested to by the fact that organizations outside of medicine often seek to be invited as participants.

Since the Public Relations Dinner at the Illinois State Medical Society's annual meeting had to be cancelled this year, the Committee on Medical Service and Public Relations suggested a meeting tied-in with the PR Institute. A further suggestion that legislative committee chairmen be invited to come up to Chicago at the same time also was approved.

While the PR chairmen attend sessions of the Institute on the 29th, the legislative chairmen will take part in a program especially arranged for them by the Law Department of the American Medical Association and the Illinois State Medical Society's Committee on Medical Service and Public Relations.

In the evening, the two Illinois groups will assemble for a dinner meeting at the Hotel Sherman where they will discuss ways of integrating the legislative and public relations programs in their respective counties. Included in the agenda will be a discussion of the state society's legislative and PR approach to the upcoming biennial assembly of the Illinois State Legislature.

This year the American Medical Association's Public Relations Department will incorporate in its Institute portions of a socio-economic program previously reserved for the PR Conferences, which were held only in connection with the American Medical Association's Clinical Sessions. In addition, there will be a half-day workshop on local programming in radio and television and discussions on science fairs, legislation, membership indoctrination and tested public relations activities.

Shown for the first time at this meeting will be the American Medical Association's new membership film, "The Case of the Doubting Doctor." Two other films will also be premiered, one a crash injury report and the other a television medical detective series.

**'THANK YOU, DOCTOR'**

An editorial bearing that headline appeared in the Chicago *Sun-Times* shortly after publication of remarks made at our annual dinner by Dr. Elmer Hess, immediate past-president of the American Medical Association. At that time Dr. Hess advised physicians to cooperate with the press to the fullest extent. Newspapermen

"are your friends, and if you are frank and honest with them, they in turn will be the same with you," he said.

"The press is entitled to report and publish a human interest story about medical care and treatment and the physicians and hospitals involved should be perfectly willing to give the facts to the press," the American Medical Association's ex-chief explained. "A well-informed press will reveal physicians in their true light as faithful servants to those individuals who suffer."

The *Sun-Times* commented:

"We are happy to note . . . that the retiring president of the American Medical Association has a high regard for the American press and its reporters and that he urges all members of the association to give the facts for stories or opinions to newspapermen when they need them. . . . We especially appreciate the growing recognition by the medical profession of the public's 'right to know' about medical matters."

**PR GRAFS**

Medical societies have often given awards to lay writers, particularly newspaper people, but Dr. Millard C. Beyer of Akron, O., is probably the first medical man to receive an award from the journalistic profession for good press work. . . . Public relations chairman and past-president of the Summit County Medical Society, Dr. Beyer recently was given the first Public Service Award for excellence in press relations presented by thee Buckeye Chapter of Sigma Delta Chi, national journalistic fraternity.

Another instance of table-turning occurred in Chicago recently when a reporter for the Chicago *American* publicly thanked a physician for refusing to bear a grudge . . . About two years ago the reporter had filed a police complaint against the M.D. for shooting a stray dog in the neighborhood. The incident was straightened out, but feelings were ruffled on both sides. . . Then came the time when the reporter's wife became severely ill and he needed a doctor in a hurry. Failing to contact his family physician, he sought out the M.D. against whom he had filed the complaint . . . The doctor immediately left a pleasant social gathering and took care of the newspaperman's wife . . . In a page one feature story recounting the history of his association with the once-aggrieved physician, the reporter concluded: "This is the only way I know how to say, 'Thanks.'"

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## Vitamin E

No clear rationale is apparent for the use of vitamin E in the menopause. Vitamin E does play a part in the reproductive process of some animals and it has been shown, in the rat, that the menopause and sterility occur earlier in animals deficient in vitamin E than in a control group. However, tocopherol deficiency is only one factor in the sterility of the aged rat. No definite difference in tocopherol levels of normal women with reproductive disorders has been demonstrated. Numerous clinical reports have appeared reporting the beneficial effects of vitamin E in the treatment of menopausal symptoms. McClaren stated that vitamin E helped to heal senile lesions in the lower genital tract. Gozan found vitamin E effective in 50 per cent of menopausal patients but pointed out that the effect may be explained by the pharmacology of placebos. Blatt, Wiesbader, and Kupperman recently produced statistical evidence to prove the point that vitamin E is no more effective than a placebo and that any value of vitamin E in the menopause must be ascribed to its placebo effect. *Joseph Rogers, M.D. The Menopause. New England J. Med. Apr.* 19, 1956.

# CORRESPONDENCE



## International College of Surgeons to hold annual congress

The 21st Annual Congress of the United States and Canadian Sections, International College of Surgeons, will be held in the Palmer House, Chicago, September 9-13. The meeting will be attended by surgical celebrities from many foreign countries as well as from all parts of the United States and Canada.

The International House of Delegates also will meet in the morning of the opening day, Sunday. In the afternoon, the House of Delegates of the United States Section will convene for the Biennial election of officers and for other business.

General assemblies will be held mornings and afternoons, Monday through Thursday. Section meetings at the same hours will cover coloproctologic surgery, neurosurgery, obstetrics and gynecologic surgery, occupational surgery, ophthalmology and otorhinolaryngology, orthopedic surgery, plastic surgery, rehabilitation services, surgical nurses and urologic surgery.

A film forum will be presented on Monday evening. All-day scientific motion picture programs will be given Monday through Thursday.

The annual banquet will be on Wednesday evening. The annual convocation will take place in the Civic Opera House on Thursday evening.

The Canadian Section will hold a business meeting Monday afternoon and its dinner will be given that evening. A daily program will be presented by the Woman's Auxiliary. There will be daily tours through the International Surgeons Hall of Fame.

A special post assembly clinical day, open to all physicians, will be held in the Cook County Hospital on Friday.

Dr. Raymond W. McNealy, Chicago, is general chairman; Dr. Peter A. Rosi, Chicago, program chairman; Dr. Karl A. Meyer, Chicago, and Dr. Lyon H. Appleby, Vancouver, B.C., co-chairmen; Dr. Ross T. McIntire, Chicago, executive director.

Further information may be had by writing to the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Illinois.

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## Postgraduate courses on diseases of the chest

We wish to announce that the Council on Postgraduate Medical Education of the American College of Chest Physicians will sponsor the following Postgraduate Courses on Diseases of the Chest this fall:

11th Annual Postgraduate Course, Chicago, Illinois, Hotel Knickerbocker, October 15-19.

9th Annual Postgraduate Course, New York City, Park-Sheraton Hotel, November 12-16.

Tuition for each course is $75 which will include daily round table luncheons. The most recent advances in the diagnosis and treatment of chest diseases will be covered.

Further information may be obtained by

writing: Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

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## Clinics for crippled children listed for September

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois Division of Services for Crippled Children. The Division will count 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 2 special clinics for children with cardiac conditions, 1 for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The September clinics are:

September 5 - Hinsdale, Hinsdale Sanitarium

September 5 - Rock Island [Cerebral Palsy], Foss Home, 3808-8th Avenue

September 6 - Clinton, Christian Church

September 6 - Sterling, Field House

September 6 - Rosiclare, Y.M.C.A. Building

September 11 - E. St. Louis, St. Mary's Hospital

September 11 - Peoria, Children's Hospital

September 12 - Joliet, Will County T.B. Sanitarium

September 13 - Elmhurst, Memorial Hospital of Dupage County

September 13 - Springfield, St. John's Hospital

September 14 - Chicago Heights [Cardiac], St. James Hospital

September 18 - Alton, Alton Memorial Hospital

September 19 - Centralia, Recreation Center

September 19 - Evergreen Park, Little Company of Mary Hospital

September 19 - Jacksonville, Our Savior's Hospital

September 20 - Anna, Anna County Hospital District

September 20 - Rockford, St. Anthony's Hospital

September 21 - Evanston, St. Francis Hospital

September 25 - Effingham (Rheumatic Fever), St. Anthony's Hospital

September 25 - Peoria, Children's Hospital

September 26 - Aurora, Copley Memorial Hospital

September 26 - Springfield (Cerebral Palsy), Memorial Hospital

September 27 - Decatur, Decatur-Macon Hospital

September 27 - Chester, St. John's Lutheran School

September 28 - Chicago Heights [Cardiac], St. James Hospital

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## American Rhinologic Society annual meeting

The American Rhinologic Society will hold its annual meeting in Chicago, October 9-13.

The first evening will be devoted to a business session. A series of surgical demonstrations and seminars will be presented in the Illinois Masonic Hospital from 8 a.m. to 10 p.m. on the three following days. These will cover many phases of rhinology and will be conducted under the direction of Dr. Maurice H. Cottle, professor and chairman of the department of otolaryngology, Chicago Medical School.

The annual scientific program will be presented in the Palmer House on the closing day. This will include a morning symposium on "Expanding Horizons in Rhinology," with the following participants:

Dr. Charles J. Petrillo, Yale University School of Medicine, New Haven. (Anatomy)

Dr. Newton D. Fischer, University of North Carolina School of Medicine, Chapel Hill. (Physiology)

Dr. Harold S. Ulvestad, University of Minnesota Medical School, Minneapolis. (Surgery)

Dr. French K. Hansel, Washington University College of Medicine, St. Louis. (Allergy)

Guest speakers on the afternoon program will be:

Dr. Roy R. Grinker, director of the Institute for Psychosomatic and Psychiatric Research, Michael Reese Hospital, Chicago, "The Psychosomatic Approach to Rhinological Problems."

Dr. Conrad Pirani, professor of pathology, University of Illinois College of Medicine, Chicago, "The Connective Tissue in Wound Healing."

Hubert R. Catchpole, Ph.D., research associate professor of pathology, University of Illinois College of Medicine, Chicago, "Newer Ideas on the Significance of Ground Substance of Connective Tissue."

Dr. Matthew S. Ersner, professor of otolaryngology and rhinology, Temple University, Philadelphia, will be the guest of honor and speaker at a dinner in the evening. The toastmaster will be Dr. Ralph H. Riggs, Shreveport, president of the Society.

The profession is welcome to attend the scientific session as guests of a member of the Society. There is no registration fee.

Further information may be had by writing to Mrs. Mabel Campbell, corresponding secretary, 834 Wellington Avenue, Chicago 14, Illinois.

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## Mississippi Valley Medical Society meeting

The 21st Annual Meeting of the Mississippi Valley Medical Society will be held at the Hotel Morrison, Chicago, Sept. 26, 27, 28. Over 50 clinical teachers from leading medical schools will conduct this — "The Midwest's Greatest Intensive Postgraduate Medical Assembly", which will present the latest advances in medicine. The program will include 6 panel discussions: Sept. 26, Recent Advances in Diagnosis and Therapy; Osseous Trauma. Sept. 27, Gynecology; Coronary Thrombosis. Sept. 28, Arthritis and Rheumatic Disease; Thyroid Disease.

The program will be conducted by leading clinicians from the the medical schools of Chicago, St. Louis, Iowa City, Minneapolis, Milwaukee, Madison and Rochester, Minn., plus a number of clinicians from more distant states including Dwight Murray, President of the American Medical Association, Paul D. White of Boston, John Adriani of New Orleans, Dwight Ensign and Charles G. Johnston of Detroit, A. Carleton Ernstene and Charles C. Higgins of Cleveland, Claude J. Hunt of Kansas City, Mo., A. Hamblin Letton of Atlanta, and H. Marvin Pollard of Ann Arbor.

All members of the AMA are cordially invited and urged to attend. There will be a large technical and scientific exhibit hall. The 13th annual meeting of the American Medical Writers' Association, will also meet at the Hotel Morrison, Sept. 28-29. Further details of both meetings may be obtained from Harold Swanberg, M.D., Secretary, 209-224 W.C.U. Building, Quincy, Ill. (There will be a special program for visiting ladies and every physician is urged to bring his wife with him.)

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## Urology award

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300 and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to hospital interns and residents doing research work in urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel William Penn, Pittsburgh, Pennsylvania, May 6-9, 1957.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1956.

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## Booklet of anatomical transparencies distributed by Pfizer

The latest in a series of full color anatomical illustrations, printed on transparent acetate and bound into a booklet to give an effect of visual segmental anatomy as the pages are turned, has just been issued by Pfizer Laboratories, division of Chas. Pfizer & Co., Inc.

The booklet, prepared with the assistance of Dr. Philip Thorek of the University of Illinois, deals with the adrenal glands and kidneys. It includes a short description of salient features of surgical anatomy of the kidney and adrenal gland and transparencies and stereogram by Dr. Hans Elias, described by him and Dr. John E.

Pauly, both of the Chicago Medical School. The stereogram shows the histology of the adrenal cortex.

The transparencies are offered only to physicians by Pfizer's professional service representatives, and have proven to be highly prized for reference purposes and as teaching aids. The first threee of the five booklets, are now out of stock.

The fourth and fifth booklets, still in print, were executed by Dr. Elias. The fourth, with text by Dr. M. Edward Davis, also of the Chicago Medical School, shows the pregnant uterus at nine weeks gestation.

The entire project was conceived and supervised by E. W. Whitney and E. J. Mills of the Pfizer Laboratories advertising department and Dr. Leo L. Leveridge of the medical department.

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## Annual session of The American College of Physicians

1957—38th Annual Session, Boston, Mass., April 8-12.

Richard P. Stetson, M.D., F.A.C.P., 203 Commonwealth Ave., Boston 16, Mass., General Chairman.

Walter L. Palmer, M.D., F.A.C.P., University of Chicago Department of Medicine, Chicago 37, Ill., President.

Edward R. Loveland, 4200 Pine St., Philadelphia 4, Pa., Executive Secretary and General Manager.

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## Electrocardiographic text book

Issuance of a two-volume "Electrocardiographic Text Book" has been announced by the American Heart Association. The 'EKG'-volumes are designed for teaching electrocardiography in the medical schools and for post graduate study by physicians. The work is edited by Travis Winsor, M.D., Los Angeles.

Included in the first volume of the text book are 119 electrocardiograms, each of which is accompanied by several pertinent questions. There also is a section containing 230 general questions on electrocardiography and an appendix which includes a table of normal values. The second volume contains interpretations and discussions of the electrocardiograms and answers to the questions.

The "EKG Text Book" is the result of a two-year project commissioned by the Heart Association's Committee on Professional Education. Dr. Winsor was assisted in the preparation of the volumes by 34 leading authorities in the field of electrocardiography. These physicians reviewed the work and many of their suggestions were incorporated into the final text.

Copies of the "EKG Text Book" are available from the Illinois Heart Association, 526 South Seventh Street, Springfield, Illinois. Cost is $5.00 per set.

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## Polio vaccine

Poliomyelitis vaccine can now be requested from the Illinois Department of Public Health for children who have reached six months of age and who have not passed their 20th birthday, and pregnant women.

Physicians submitting lists of patients who request vaccine will be given vaccine for two inoculations for each eligible person listed. (2 doses, 1 cc., 4-week interval.)

Individuals between the ages of 5 and 14 who received their *first two inoculations prior to December* 1, 1955 are now eligible to receive their third inoculation from their family doctor. This includes the children who received their inoculations under the auspices of the National Foundation for Infantile Paralysis.

Parents who wish to have their children receive poliomyelitis vaccine inoculations should contact their family doctor so that he in turn can request the vaccine for them. 6-15-56.

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# AT THE EDITOR'S DESK



THE antibiotics are in the news again. A release from the Office of the Surgeon General says that terramycin will prevent Q fever if given — not soon after exposure — but late in the incubation period. In addition, a group of 27 volunteers were free of symptoms within 24 to 48 hours when terramycin was administered within a day after the onset of the disease.

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Albamycin® became available to physicians last month. The product is aimed at bacteria, particularly some strain of staphylococci that had developed resistance to other antibiotics. The drug was "clinically effective and well tolerated when administered orally" in a variety "of human ailments including pus-forming infections of the skin, blood stream, bone, and soft tissue."

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Ilotycin®, ophthalmic ointment was found to be superior to silver nitrate as a prophylaxis for eyes of newborn infants, according to a group of clinical investigators from the Department of Pediatrics, Washington University. They compared the effects of these two products in a study involving more than 2,300 infants in five St. Louis hospitals. Ilotycin is easy to apply and remains stable for long periods without refrigeration.

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Isoniazid is not beneficial in multiple sclerosis. This retraction came from the Veterans Administration following an investigation of a previous report that had been more favorable.

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The ninth edition of Merck Manual will be published early this fall. We never will know how many medical students got through school with the help of earlier editions. This manual was not recommended by the faculty but was used by students who needed a quick, convenient source of information to pass examinations. Those were the days.

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An editorial in the July issue of Medical Economics reports that by the time a physician gets his M.D. degree, he has invested more than $31,000 in himself. The one-year internship costs him another $4,000 earnings loss. When this is added to the cost of establishing an office, the total cost of his shingle is pushed to nearly $39,000. Physicians who wish to specialize undergo additional years of earning loss, which is estimated at a minimum of $14,000.

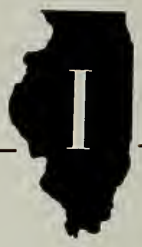
‹ ›

The Bausch and Lomb Optical Company is making a modified spectrophotometer for measuring transaminase in the blood stream. This enzyme is released into the blood by damaged tissue and is useful in diagnosing coronary thrombosis.

‹ ›

Becton, Dickinson and Company have a new automatic "hidden needle" device that minimizes the pain and fear associated with injections. The concealed needle is automatically triggered when the circular rubber foot is pressed against the skin. The injection is less painful because the needle penetrates two to three times faster than by the manual technique. The pressure of the rubber foot has a slight anesthetic effect.

# NEWS of the STATE



## CLINTON

**Society News.**—A joint meeting with the dentists of Clinton County was held at the last meeting of the season of the Clinton County Medical Society, June 13. Speakers were Norman J. Rose, M. D., on "Newer Concepts and Tests for Biologically False Positive Reactions in Suspected Cases of Syphilis" and Orvis S. Hoag, D. D. S., "Dental Health Problems of the Aging."

**Personal.**—Dr. William L. DuComb, Carlyle, made his annual hunting trip to Kodiak Island, Alaska, this spring. He was successful in killing a huge Kodiak bear which is being made into a mounted trophy for him in Denver, Colorado.

## COOK

**Personal.**—Dr. Alfred W. Kneucker, assistant professor of surgery, Chicago Medical School, recently won an award from the American Urological Association for his exhibit "Electrourogram", shown at the association's convention in San Francisco.—Dr. C. Philip Miller, professor of medicine, University of Chicago Division of Biological Sciences and noted for his investigation of infectious disease, has been elected to membership in the National Academy of Sciences.

**New York Physician Joins Chicago Faculty.**—John Lester Nickerson, Ph. D., professor of physiology at the Columbia University College of Physicians and Surgeons, New York, has been appointed chairman and professor of the department of physiology and pharmacology at the Chicago Medical School. Dr. Nickerson is a native of Halifax, but is a naturalized American citizen.

**Michael Reese Alumni Officers.**—Dr. Bernard M. Cohn was recently elected president of the Michael Reese Hospital Staff Alumni Association, and Dr. Jerome M. Silver was named secretary.

**Warren Furey Heads TB Institute.**—Dr. Warren W. Furey, a radiologist and formerly president of the Chicago Medical Society, was elected president of the Tuberculosis Institute of Chicago and Cook County, June 20.

**Israel Davidsohn Receives Recognition.**—The Morris L. Parker Award of $500 for meritorious scientific research was presented to Dr. Israel Davidsohn by the Chicago Medical School, June 16. Dr. Davidsohn is head of the school's department of pathology and pathologist and director of Laboratories at Mount Sinai Hospital.

**Ninety Year Old Physician Honored.**—Dr. Joseph Prendergast, Oak Park, aged 90, was presented with a gold service pin by the Chicago Ethical Society, June 18, for his work with the Senior Citizens Hobby Center in the Y. W. C. A. Loop headquarters, Chicago. Dr. Prendergast has been a governing member of the center since it was opened in 1950. The hobby center is to interest men and women more than 60 years of age.

**Group Hospitalization for Students.**—Northwestern University has announced a group hospitalization program for its 8,000 students on the Evanston and Chicago campuses. The plan, approved recently by the board of trustees, will be effective next fall. The program will be integrated with the existing student health service and will contain the following features:

- — Hospital coverage anywhere in the world.
- — Benefits of $17 per hospital day and $250 toward diagnostic procedures up to a maximum of $1000 per illness.
- — A surgical fee schedule up to $300.
- — An increase of campus infirmary care from 5 to 14 days per quarter.
- — Discontinuation of special fees for x-ray and laboratory work within the student health service.

— An option permitting coverage to continue during summer vacations.

— An option to permit coverage of a spouse and children.

Dr. Leona B. Yeager, student health service director, stated that special consideration was given to providing a type of health coverage that directly benefits commuter as well as resident students. She said another principal consideration was to protect students against "disaster" situations when serious injury or prolonged illness can consume funds intended for educational purposes and cause permanent withdrawal from school.

Dr. Yeager gave credit to student organizations for suggestions incorporated in the plan while it was being worked out by representatives of the University administration, the medical school, and the insurance firm.

Cost while in school for both the hospital insurance program and the health service will be $10 per quarter. Cost of optional hospital coverage during the summer vacation period will be $5 because the student will not be able to take advantage of on-campus health services.

Technological Institute students will be able to obtain hospital coverage during the periods they are off campus working in industry under the cooperative program.

Married students, most of whom are in the graduate and professional schools, may obtain coverage for a spouse at an added fee of $6.50 per quarter, which includes maternity benefits. Coverage for children will be $5.95.

Dr. Yeager said the plan is necessary to protect "the forgotten college group." She pointed out that students, upon reaching 19 years of age, cannot benefit from a parent's health insurance and cannot obtain individual coverage except at prohibitive cost. She said students under 19 who are covered by a parent's policy will obtain dual benefits.

"The Northwestern plan is following a trend toward utilizing an outside insurance organization for hospitalization benefits," Dr. Yeager said. "The plan is based on actual cost of medical care of Northwestern students.

"A similar concept is in effect at Harvard University and Massachusetts Institute of Technology. In general, student health service costs are higher than the Northwestern rate. Cornell University charges $36 for a nine-month period; Harvard University, $56.50, and Stamford University, $40."

Northwestern University News.—A Northwestern University graduate, Paul H. Jordan, Chicago, won a $250 award in an international contest for medical students sponsored by the Schering Corporation of Bloomfield, N. J. Now interning at West Suburban Hospital in Oak Park, Jordan won the second place prize for his scientific paper on recent trends in the clinical use of adrenocortical steroids. Kent Guild a junior in Northwestern University Medical School, was recently elected president of the Student American Medical Association. Dr. Jules H. Masserman, professor of neurology and psychiatry at Northwestern, has been elected president of the newly founded Academy of Psychoanalysis and of the American Society for Group Therapy and the American Society for Biological Psychiatry. Dr. Samuel N. Feinberg, professor of medicine, participated in the eightieth anniversary of the founding of MeHarry Medical College, Nashville, Tenn., June 5. He spoke on "Allergy: 1956 Inventory." Dr. Loyal Davis, chairman of the department of surgery, was recently elected president of the American Surgical Association. While attending a scientific meeting in Texas recently, Dr. Harry B. Harding, associate professor of bacteriology, was made an honorary Texan by Gov. Allan Chivers.

**Dr. Nedzel Honored on Retirement.**—More than ninety friends and associates of Dr. Alexander J. Nedzel gathered at a dinner recently to honor him on his retirement from the University of Illinois College of Medicine. Dr. Nedzel, associate professor of pathology and a member of the staff for twenty-seven years, will retire September 1. He was presented with a set of luggage.

**New Honors to Dr. Van Dellen.**—Dr. Theodore R. Van Dellen, Associate Editor of the ILLINOIS MEDICAL JOURNAL and Health Editor of the Chicago Tribune, has been elected president of the Northwestern University Alumni Association and of the North Side Branch of the Chicago Medical Society.

**Louis Newman Receives Award.**—Dr. Louis B. Newman, chief of the physical medicine and rehabilitation service at the Veterans' Administration Research Hospital, Chicago, has been given the John E. Davis Award by the Association for Physical and Mental Rehabilitation. Dr. Newman was honored for "distinguished leadership and outstanding service in the field of physical medicine and rehabilitation. Presentation was made during the association's annual meeting in Augusta, Ga., June 25-29.

**New Psychiatric Officers.**—Dr. Hugh T. Carmichael was elected president of the Illinois Psychiatric Society at its meeting, May 16. Other officers are Drs. Kalman Gyarfas, vice president; Alberto de la Torre, secretary-treasurer; and Roy R. Grinker and George R. Perkins, councilors.

**Faculty Changes at University of Chicago.**—New appointments to the medical staff of the University of Chicago Division of Biological Sciences are Drs. R. Hugh Dickinson as associate professor of psychiatry, and J. Frederick Bell as director of viral and rickettsial fever research for the U. S. Navy in Cairo, Egypt. The Cairo project is directed by the University of Chicago for the Navy.

Dr. Dickinson has been in private practice in Omaha, Neb., and has also served part-time as associate professor of psychiatry at the University of Nebraska Medical School and assistant director of the Nebraska Psychiatric Institute in charge of

training and education. Dr. Bell was formerly a staff member of the U. S. Public Health Service at the Rocky Mountain Research Laboratory in Montana.

Promotions at the medical school include the following: Dr. Edith Potter to professor of pathology in the department of obstetrics and gynecology; Lester B. Skaggs, director of the Health Physics Service, to professor of radiology; Kenneth P. DuBois, director of the U. S. Air Force Radiation Laboratory at the university, to professor of pharmacology; Dr. Loyd J. Roth, associate professor of pharmacology and expert on the use of radioactive tracers to study tissue disease; Dr. Charles P. McCartney, associate professor of obstetrics and gynecology; Dr. Theodore N. Pullman, associate professor of medicine; Dr. David W. Talmage, associate professor of medicine; Dr. William R. Barclay, associate professor of medicine, and Dr. David J. Lochman, associate professor of radiology.

**Specialty Society Elections.**—Dr. Knowlton E. Barber was recently named president of the Chicago Urological Society. Other officers are Drs. J. Lester Wilkey and Don E. Murray vice-president and secretary-treasurer, respectively.—At the recent meeting of the Chicago Society of Internal Medicine, Dr. Joseph B. Kirsner was chosen president; Dr. Fred E. Ball, vice president, and Dr. Franklin A. Kyser, secretary-treasurer.—New officers of the Metropolitan Dermatological Society of Chicago are Drs. James J. Barrock, president; Cleveland J. White, vice president, and Tibor Benedek, secretary-treasurer.—At the May 15 meeting of the Chicago Pediatric Society, the following officers were elected Drs. S. C. Henn, president; Ralph H. Kunstadter, vice president; Raymond F. Grissom, secretary; Noel G. Shaw, treasurer; Howard Traisman, editor, and Alfred Traisman, Eugene T. McEnery, and Maxwell P. Borovsky, executive committee.—New officers of the Chicago Laryngological and Otological Society are Drs. Raymond W. Kerwin, president; Frank Wojniak, vice-president, and Stanton A. Friedberg, secretary-treasurer.—Officers of the Chicago Dermatological Society are Drs. Louis C. Brunsting, Rochester, Minn., president; Albert H. Slepyan, vice president, and Samuel M. Bluefarb, secretary-treasurer. New officers of the Chicago Society Of Industrial Medicine and Surgery are: President, Cornelius M. Annan, M.D.; Vice-President, Kenneth F. Stotz, M.D.; Secretary, Bille Hennan, M.D.; Treasurer, Charles Drueck, M.D.—Officers of Chicago Neurological Society are: President, Irving C. Sherman, M.D.; Vice-President, Ernst Hasse, M.D.; Secretary-Treasurer, Oscar Sugar, M.D.—Officers of the Chicago Gynecological Society are: President, Ronald R. Greene, M.D.; President-Elect, A. F. Lash, M.D.; Vice-President, Charles Fields, M.D.; Treasurer, Robert Al Beebe, M.D.; Secretary, Clyde J. Geiger, M.D.; Pathologist, Charles J. Smith, M.D.; Editor, Cecil C. Draa, M.D.

## WINNEBAGO

**New Members.**—The Winnebago County Medical Society has accepted into membership the following physicians: Danguole K. Surantas who became a citizen of the United States, April 11, 1956 after completing a residency in anesthesiology; At the present time she practices anesthesiology and lives at 1920 Sharon Avenue; Dr. Hugo Mathiesen who became a citizen of the United States April 10; his office is located at 5340 North Second Street; and Dr. Joseph P. Berger who is on the ophthalmology staff of the Canfield Clinic.

## GENERAL

**Medical Student Representatives to Attend Meeting at Surgeons' Expense.**—For the first time, student representatives from sixteen medical schools will attend the forty-second annual Clinical Congress of the American College of Surgeons at College expense. The meeting will be held in San Francisco, October 8-12, 1956. The College believes that education obtained through attendance at scientific programs such as the Congress is as valuable to students as to practicing physicians. In support of this belief, and in cooperation with deans of approved medical schools of this country and Canada, it is planned that a number of senior medical students will attend Congress meetings every year. Schools will participate in rotation, depending on the geographic location of the meeting. Students will be selected by vote of their classmates. At the Congress, fellow-sponsors will meet with and advise the students daily to insure that each student obtains the maximum benefit from this educational experience. This year Dr. Michael L. Mason, Chicago, will give the Annual Oration on Trauma. His subject will be "Treatment of Open Wounds."

**New Service to Help Hospitals Simplify Medical Records.**—The Commission on Professional and Hospital Activities has been organized, it was announced June 23. Established by the American College of Surgeons, American Hospital Association, American College of Physicians and the Southwestern Michigan Hospital Council, the new commission will conduct a medical statistical service that will help hospitals simplify medical records and analyze records more effectively for improvement of medical and administrative practices. The W. K. Kellogg Foundation, Battle Creek, Mich., has granted $260,000 to the Commission to support the program for three years, after which it is expected the service may be continued on a self-sustaining basis.

Members of the Commission appointed by the participating organizations are Drs. Paul H. Hawley and Robert S. Myers, director and assistant director, respectively, of the American College of Surgeons; Dr. C. Wesley Eisele, director of postgraduate medical education, University of Colorado School of Medicine, Denver, and Dr. Eliot E. Foltz, Winnetka, Ill., representing the American College

of Physicians; Dr. Edwin L. Crosby, director, and Maurice J. Norby, deputy director, representing the American Hospital Association, and C. Tiffany Loftus, director of Mercy Hospital, Benton Harbor, Mich., representing the Southwestern Michigan Hospital Council.

**Former Chicago Physician Awarded Medal.**—Dr. Henry C. Sweany, formerly director of laboratories and research at the Chicago Municipal Tuberculosis Sanitarium and now director of research, pathology and allied sciences, Missouri State Sanatorium, Mount Vernon, was presented with the medal awarded annually by the American College of Chest Physicians for outstanding contributions in the field of chest pathology. According to a news release, Dr. Sweany was the first in America to use cultures on a large scale in the routine diagnosis of tuberculosis; to use culture media for finding bovine bacilli directly from diseased tissues; to use successfully the x-ray defraction method of determining detrimental silica in tissues; to use matched controls in experimental treatment of tuberculosis; to use blood chemistry methods in the hospitals of Chicago. Dr. Burgess L. Gordon, Philadelphia, is the new president-elect of the college of chest physicians. Dr. Herman J. Moersch, Rochester, Minn., is president. Illinois physicians holding office in the college are Drs. Charles K. Petter, Waukegan treasurer, and Albert H. Andrews, Chicago, assistant treasurer. Dr. Otto L. Bettag, Chicago and Springfield, serves as regent of the college for Illinois and Indiana and Dr. Darrell H. Trumpe, Springfield, serves as governor.

**Sale of Raw Milk Banned.**—Except under certain specified conditions, the sale of raw or unpasteurized milk for direct human consumption has been prohibited, effective July 1, 1956. In accordance with a state law, unpasteurized milk sold for human consumption by the producer on premise where produced must be free from sediment and come from animals that have been tested for both tuberculosis and brucellosis. In addition to these requirements, the law forbids the retailing for human consumption of unpasteurized milk distributed by the producer which has a bacterial count of more than 50,000 per cubic centimeter as determined by specified laboratory tests.

According to the Illinois Health Messenger for June, about 95 per cent of the milk marketed at retail in Illinois is pasteurized. A law, which becomes effective July 1, 1957, requires that all fluid milk sold in the state at retail for human consumption must conform to the requirements of the "Grade A" milk law. These requirements include pasteurization.

**"Your Doctor Speaks" on FM Station WFJL.**—The following physicians have recently appeared in transcribed broadcasts of FM Station WFJL, Thursday evenings at 7:45 p.m. The series, entitled "Your Doctor Speaks" is presented by the Educational Committee of the Illinois State Medical Society:

Herman Chor, attending neuropsychiatrist, Wesley Memorial Hospital, June 28, on The Depressive States—Their Recognition and Treatment.

Robert E. Lee, associate clinical professor of medicine, Stritch School of Medicine of Loyola University, July 5, 1956, on Adequate Diet Important to Health.

Edmond R. Hess, clinical assistant in pediatrics, Northwestern University Medical School, July 12, on Current Immunizations in Infants and Children.

Emery G. Grimm, associate in medicine at Northwestern University Medical School, July 19, on Causes of Obesity.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

Joseph A. Bertucci, clinical instructor in pediatrics, Stritch School of Medicine of Loyola University, William Penn Nixon Parent-Teachers Association, September 11, on Child Safety.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Frederick L. Phillips**, a member of the staffs of St. Luke's and Children Memorial Hospitals, Effingham County Medical Society in Effingham, August 13, on Common Emergencies in Infancy.

**John J. Brosnan**, clinical instructor in surgery, Stritch School of Medicine of Loyola University, Kankakee County Medical Society in Kankakee, on September 18, Lung Tumors.

**Louis C. Johnston**, clinical assistant in medicine, University of Illinois College of Medicine, Iroquois County Medical Society in Watseka, September 18, on Treatment of Essential Hypertension.

**Wayne B. Slaughter**, associate clinical professor of surgery, Stritch School of Medicine of Loyola University, September 25, on Newer Concepts of Cleft Palate.

## DEATHS

**Irving F. Barnett***, Chicago, who graduated at the University of Illinois College of Medicine in 1913, died June 26, aged 64. He was associate clinical professor of ophthalmology at Stritch School of Medicine of Loyola University, and senior ophthalmologist at Henrotin Hospital, where he had been a member of the staff since 1937.

**Lloyd J. Blakeman***, retired, Antioch, who graduated at the Chicago College of Medicine and Surgery in 1917, died July 7, aged 64. He was a member of the staffs of Chicago Memorial and Columbus Hospitals.

**Placid A. Chiasson***, Pittsfield, who graduated at Bennett Medical College in 1915, died recently, aged 70.

**Philip H. Dechow***, Kinderhook, who graduated at Keokuk Medical College, College of Physicians and Surgeons, in 1906, died April 7, aged 79.

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*Indicates Member of the Illinois State Medical Society.

**Harry A. Durkin***, Peoria, who graduated at Harvard Medical School in 1915, died recently, aged 66. He was a specialist certified by the American Board of Internal Medicine.

**Harry R. Folckemer***, Quincy, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died May 3, aged 75. He practiced in Bowen for 37 years and joined the staff of the Illinois Soldiers' and Sailors' Home in 1942.

**Edward Charles Franing***, Galesburg, who graduated at Rush Medical College in 1899, died March 17, aged 87, of arteriosclerosis. He was past-president of the Knox County Medical Society and a member of the staff of St. Mary's Hospital and Galesburg Cottage Hospital.

**Grover Q. Grady***, Highland Park, who graduated at Rush Medical College in 1919, died June 23, aged 63, in Eagle River, Wisconsin. He was for many years president of the staff of the Highland Park Hospital.

**John Fonrose Lawson***, Sullivan, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died in St. Mary's Hospital in West Palm Beach, Florida, February 29, aged 77, of heart disease. He was a member of the staffs of Decatur and Macon County Hospital in Decatur and Memorial Hospital in Mattoon.

**Patrick A. Murphy**, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died December 21, aged 73, of bronchopneumonia.

**George Roscoe Nichols**, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1911, died in Miami, Florida, April 6, aged 68, of myocardial infarction.

**Eugene T. Phelps***, retired, formerly of Chicago and recently of Hebron, Nebraska, who graduated at Rush Medical College in 1912, died June 15, aged 71. He was formerly a member of the staff of the Woodlawn Hospital.

**Pedro M. Santos***, retired, Chicago, who graduated at Meharry Medical College in 1914, died in Milwaukee while on a motor trip, June 25, aged 69. He was a member of the staff of the Provident Hospital from 1919 until his retirement three years ago and was head of its obstetrical department from 1939 to 1951.

**Julius Steinfeld***, Chicago, who graduated at Universität Heidelberg Medizinische Fakultät, Baden, Germany, in 1920, died in Zurich, Switzerland, where he was vacationing, June 27, aged 60. He was the founder and medical director of the Forest Sanitarium, Des Plaines.

**Aloysius C. Strunk**, Chicago, who graduated at Jenner Medical College in 1916, died June 25, aged 68. He was a member of the staff of the Woodlawn Hospital and was a retired member of the Swift and Company medical staff.

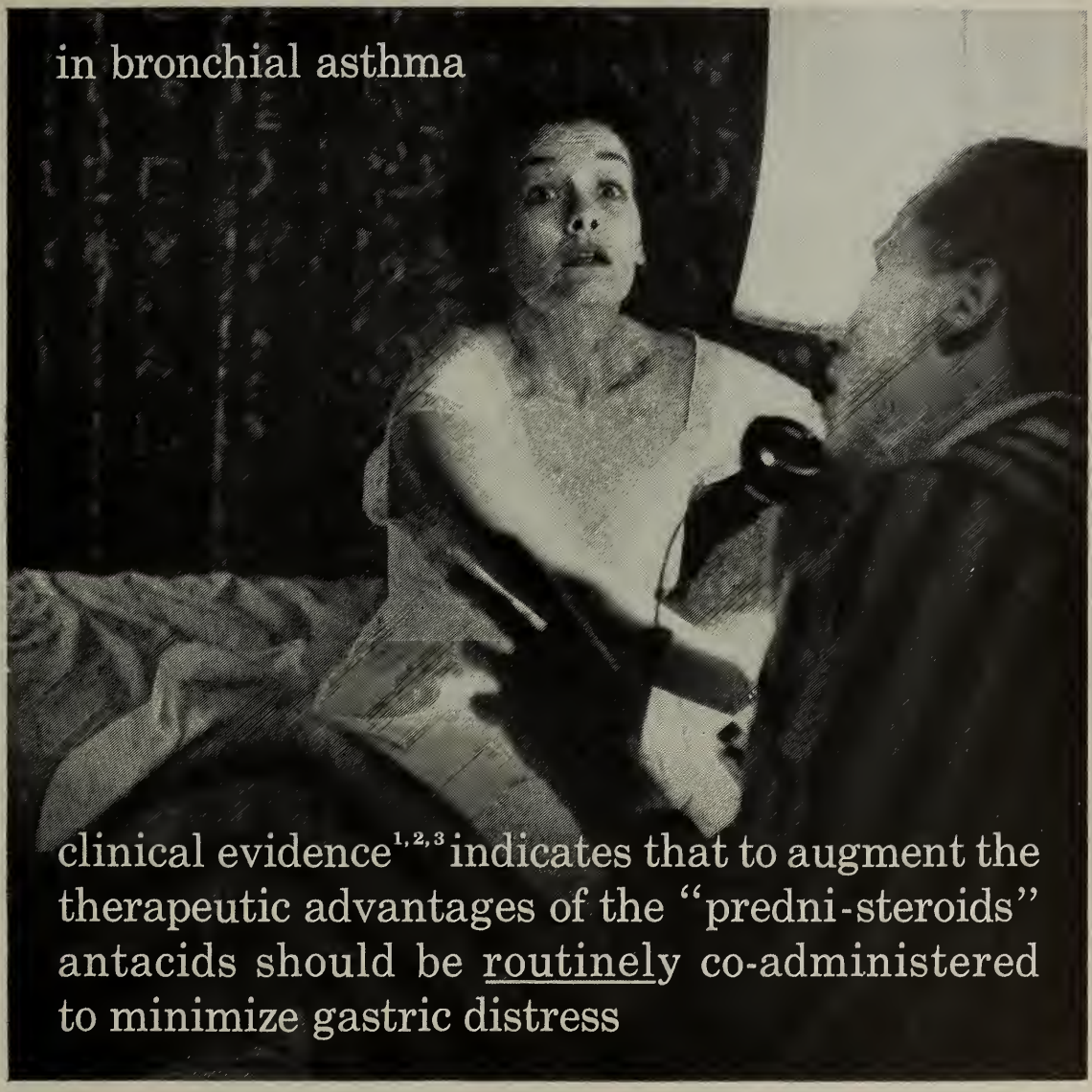
**Frederick Cleveland Test***, retired, Chicago, who graduated at Georgetown University School of Medicine, Washington, D. C., in 1895, died July 8, aged 87. Before he retired seven years ago, he was chief orthopedic surgeon at Cook County Hospital and associate professor of Bone and Joint Surgery emeritus at Northwestern University Medical School.

**Hobart Hare Todd**, Skokie, who graduated at Loyola University School of Medicine in 1940, died in March, aged 43. He was certified by the National Board of Medical Examiners.

**John F. Van de Roovaart***, retired, Chicago, who graduated at Northwestern University Medical School in 1896, died June 21, aged 84. He was a former staff member of the Roseland Community Hospital.

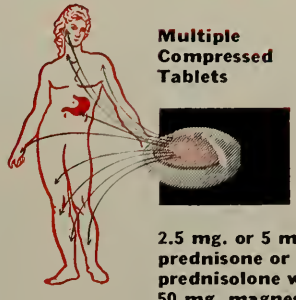
**Edward H. Weld***, Rockford, who graduated at the University of Michigan Medical School in 1907, died at Rochester, Minnesota, July 6, aged 75, of leukemia. He had practiced medicine in Rockford for many years; was president of the Illinois State Medical Society in 1943; a delegate from Winnebago County Medical Society, and delegate to the American Medical Association over a long period of time.

*Indicates member of the Illinois State Medical Society.




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**Multiple Compressed Tablets**

# 'Co-Deltra'

**2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.**

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

*References:* 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al, J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al, J.A.M.A.* 158:459, (June 11,) 1955.

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# BOOK REVIEWS



Henry Ford Hospital. International Symposium on Cardiovascular Surgery. Studies in Physiology, Diagnosis and Techniques. Edited by: Conrad R. Lam, M.D., Surgeon in charge, Division of Thoracic Surgery, Henry Ford Hospital. W. B. Saunders Co. 543 pp. $12.75.

The Staff of Henry Ford Hospital in Detroit, in 1954 asked four eminent authorities from outside the staff to assist them in sponsoring an international symposium on the subject of surgery of the heart and great vessels. This group held this symposium in March, 1955.

"It was thoroughly understood that the symposium was not to be a postgraduate course," — but rather it would be an opportunity for the presentation of actual new and perhaps controversial work. One day was spent on congenital heart, another on acquired heart disease, another on surgery of the aorta and other arteries.

Sixty workers, many of whom resided in countries other than the United States, were invited to participate in this project. The final registration list included physicians from 35 states and from 18 other countries.

This volume contains the material which was presented during the 2½ days of the symposium.

For readers who are not especially informed and trained in this technical subject, this volume will be found exceedingly readable and perhaps intriguing. Even for the most efficiently perfected in heart surgery, this volume presents the "ultimate." And when the array of physicians and scientists who took part in this symposium is surveyed, the use of the word "ultimate" is none too superlative.

This book cannot be too highly praised. It is worth the money from anybody's pocket, if only to be read as a means to satisfy curiosity. It reads like delightful fiction. However, this is no fiction but actual facts.

The illustrations are numerous and the diagrams, photographs, X-rays, cardiograms, and pathological sections add immensely.

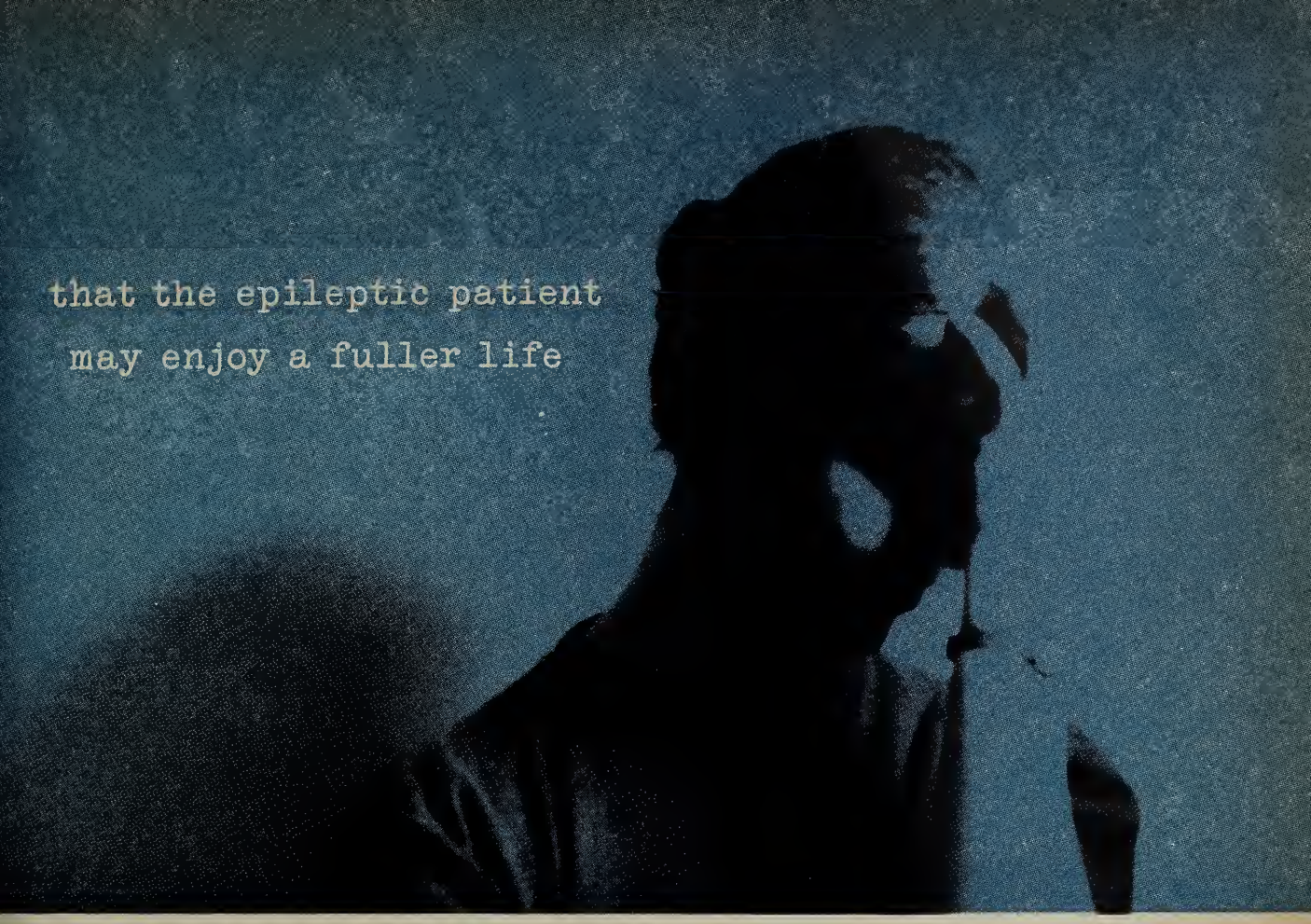
C. P. B.

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MEDICAL PROBLEMS OF OLD AGE. By Extom Smith, M.A., M.D., M. R. C. P., Physician. Whittington Hospital, London, with a foreword by The Rt. Hon. Lord Amulee, M.A., M.D. F.R.C.P. Briston: John Wright & Sons, Ltd. 314 pp. $7.00.

The author states in the preface that "Old Age modifies the manifestations of morbid prescenses. Thus in the aged, many diseases have a different clinical expression and natural course

(*Continued on page* 48)




# DILANTIN® SODIUM

(diphenylhydantoin sodium, Parke-Davis)



For patients with grand mal and psychomotor seizures, DILANTIN — alone or in combination — continues as an anticonvulsant of choice. Effective control of seizures, with resulting greater social acceptance and increased vocational opportunities, forecasts a fuller life for such patients. DILANTIN has little or no hypnotic effect.

DILANTIN Sodium is supplied in a variety of forms — including Kapseals® of 0.03 Gm. (½ gr.) and 0.1 Gm. (1½ gr.) in bottles of 100 and 1,000.

# MILONTIN® Kapseals and Suspension

(phensuximide, Parke-Davis)



For patients with petit mal epilepsy, a drug of choice in initiating treatment — with very few and mild side effects.

MILONTIN Kapseals, 0.5 Gm., bottles of 100 and 1,000; also available as MILONTIN Suspension (250 mg. per 4 cc.) in 16-ounce bottles.

For patients with mixed grand mal—petit mal epilepsy, compatibility permits use of DILANTIN with MILONTIN.

MEDICAMENTA

PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

from those encountered in younger persons." He states further, although old age is unavoidable, many of the adverse effects of physical and mental deterioration due to disease are preventable.

A great number of ailments and diseases that may occur in the elderly patients are discussed. The reader is cautioned to be more particular in considering every facet of every symptom as well as the therapy because of the age of the patient.

C. P. B.

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BLACKISTON'S NEW GOULD MEDICAL DICTIONARY, Second Edition: Norman L. Hoerr, M.D. and Arthur Osol, Ph.D., Editors. McGraw-Hill Book Company, New York, 1956. $11.50.

The editors of this fully revised, second edition had the assistance of 88 contributors from specialized fields. Since the first edition of this dictionary appeared in 1949, it has been necessary to add 12,000 new terms and 8,000 changes to keep the volume up to date.

The term "Gould" has been most popular in considerations of medical dictionaries since the first New Medical Dictionary — Gould, was published in 1890. Then four years later, 1894, An Illustrated Dictionary of Medicine, Biology and the Allied Sciences — Gould, appeared. The reviewer is fortunate in having both of these fine books in his library, inherited from a physician-father whose practice dated back to 1880.

Medical dictionaries are the most essential of all medical publications in the office of the practitioners of medicine and they will undoubtedly be used more often than any other book in the library. With the ever increasing number of pharmaceutical items developed each year, and the improvements in all branches of medicine, a medical dictionary must be completely up to date to be of greatest value to the physician.

(*Continued on page* 50)



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Your most fastidious patient will not hesitate to use this dainty, feminine, yet medically proven specific for vulvo-vaginal infections. Clinically effective in Leukorrhea, Trichomonas and Monilia vaginitis.

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Pharmacologic and clinical evaluation has shown rescinnamine to be similar to reserpine in antihypertensive activity, but to be considerably less sedative and much less apt to lead to lethargy and mental depression.[4, 5]

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The dosage of Rauwiloid is simple and definite: Merely two 2 mg. tablets at bedtime. For maintenance, one tablet usually suffices.


1. Klohs, M.W.; Draper, M.D., and Keller, F.: Alkaloids of Rauwolfia Serpentina Benth. III. Rescinnamine, a New Hypotensive and Sedative Principle, J. Am. Chem. Soc. 76:2843 (1954).
2. Cronheim, G.; Brown, W.; Cawthorne, J.; Toekes, M.I., and Ungari, J.: Pharmacological Studies with Rescinnamine, a New Alkaloid Isolated from Rauwolfia Serpentina, Proc. Soc. Exper. Biol. & Med. 86:120 (May) 1954.
3. Gourzis, J.T.; Sonnenschein, P.R., and Barden, R.: Alterations in Cardiovascular Responses of the Dog Following Rauwiloid, an Alkaloidal Extract of Rauwolfia Serpentina, Proc. Soc. Exper. Biol. & Med. 85:463 (Mar.) 1954.
4. Hershberger, R.; Hughes, W., and Dennis, E.: Clinical Results in the Treatment of Hypertension with Rescinnamine, Clin. Res. Proc. 3:71 (Feb.) 1955.
5. Smirk, F.H., and McQueen, E.G.: Comparison of Rescinnamine and Reserpine as Hypotensive Agents, Lancet 2:115 (July 16) 1955.


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## BOOK REVIEWS (Continued)

The many developments in the field of isotopes, chest surgery, biochemistry, psychiatry with the many new drugs which have been developed during the past five years, as well as many other newer fields in the application of medical and surgical care, have made it necessary for a complete revision of the New Gould Dictionary. The reviewer is thoroughly convinced that this book near the desk of the up to date practitioner will be used many times daily in his work. The many contributors carefully selected by the editorial board have added materially to the value of this dictionary. We predict that this edition will be more popular than ever before with the medical, dental, veterinary medicine practitioners, as well as members of allied professions throughout the nation.

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Home is the one place in all this world where hearts are sure of each other. It is the place of confidence. It is the spot where expressions of tenderness gush out without any dread of ridicule.

Frederick W. Robertson

## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Endogenous Uveitis: By Alan C. Woods, M. D., Professor Emeritus of Ophthalmology, Johns Hopkins University. Illustrated by Annette Smith Burgess. Williams & Wilkins Company, Baltimore, 1956. Price $12.50.

Physical Diagnosis: By Ralph H. Major, M. D., Professor of Medicine & History of Medicine, University of Kansas, and Mahlon H. Delp, M. D., Professor of Medicine, University of Kansas. Fifth Edition. 536 Illustrations. W. B. Saunders Company, Philadelphia, 1956. Price $7.00.

The Morphology of Human Blood Cells: By L. W. Diggs, M. A., M. D., Professor of Medicine and Director of Medical Laboratories, University of Tennessee and City of Memphis Hospitals. Consultant in Hematology, Armed Forces Institute of Pathology, Washington, D.C.; Dorothy Sturm, Instructor, Memphis Academy of Arts; and Ann Bell, B. A. Instructor in Medicine, University of Tennessee. 54 illustrations. W. B. Saunders Company, Philadelphia, 1956. Price $12.00

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## How justice triumphed

We have gained in areas of housecleaning. Euthanasia, unnecessary abortions, and unnecessary surgery have come under the careful scrutiny of newly appointed committees. Much prestige is gained when the leaders of our communities hear that we are policing ourselves. In Savannah, we have just been through a most disagreeable ordeal. A fellow physician brought suit against 14 of the leading medical men of our city. When they had made it impossible for him to operate in the last hospital in which he had privileges, he publicly accused his colleagues of conspiracy. In his 7 million dollar suit, five weeks of protracted insults were leveled against 14 men of integrity. Throngs of Savannah citizens attended the trial. More newspaper space than any event since Oglethorpe climbed the bluff for the first time was devoted to this bitter experience. I mention this trial not so much because the honest physicians won over their adversary or because justice triumphed but because — out of the agony and the torment and the expose of the personal lives of the defendants — came a healing response on the part of the Savannah public. These 14 men took it upon themselves independently and without the assistance of any organized medical group to remove from our community a colleague who they knew was engaged in unethical practices. Knowing full well that they themselves would be subjected to all the insults of a clever attorney, they made it impossible for the culprit to perform surgery in the only hospital in which he had privileges. He in turn sued these honorable men for 7 million dollars, claiming they had conspired against him. If any award were possible or national recognition given, these men whose good names were in jeopardy and whose expenses were over $25,000 should receive the personal thanks of every physician in America. This was a great effort but we can expect no less from members of this great profession. It is this type of courageous action which the public understands and which it expects from the medical community. *Peter L. Scardino, M.D. The Case for Social Medicine. J. Kentucky M.A. March* 1956.

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The greater the obstacle, the more glory in overcoming it.

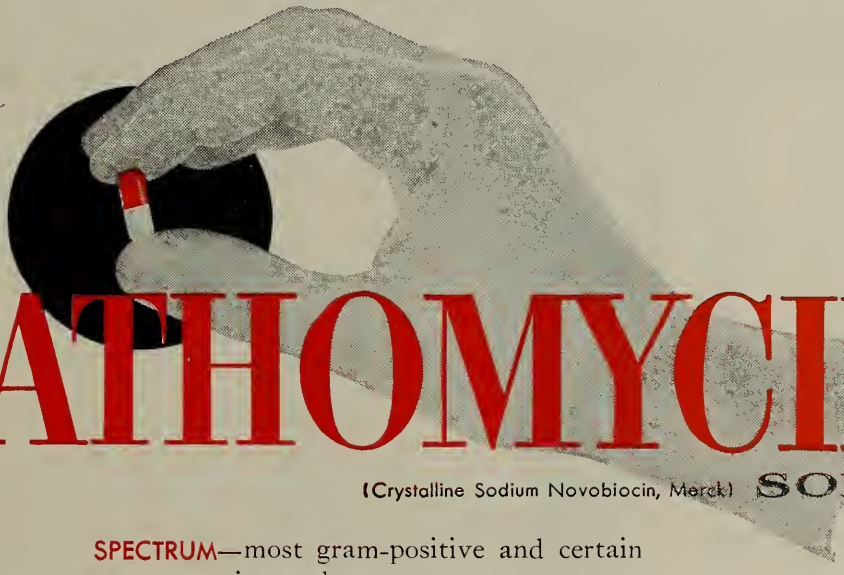
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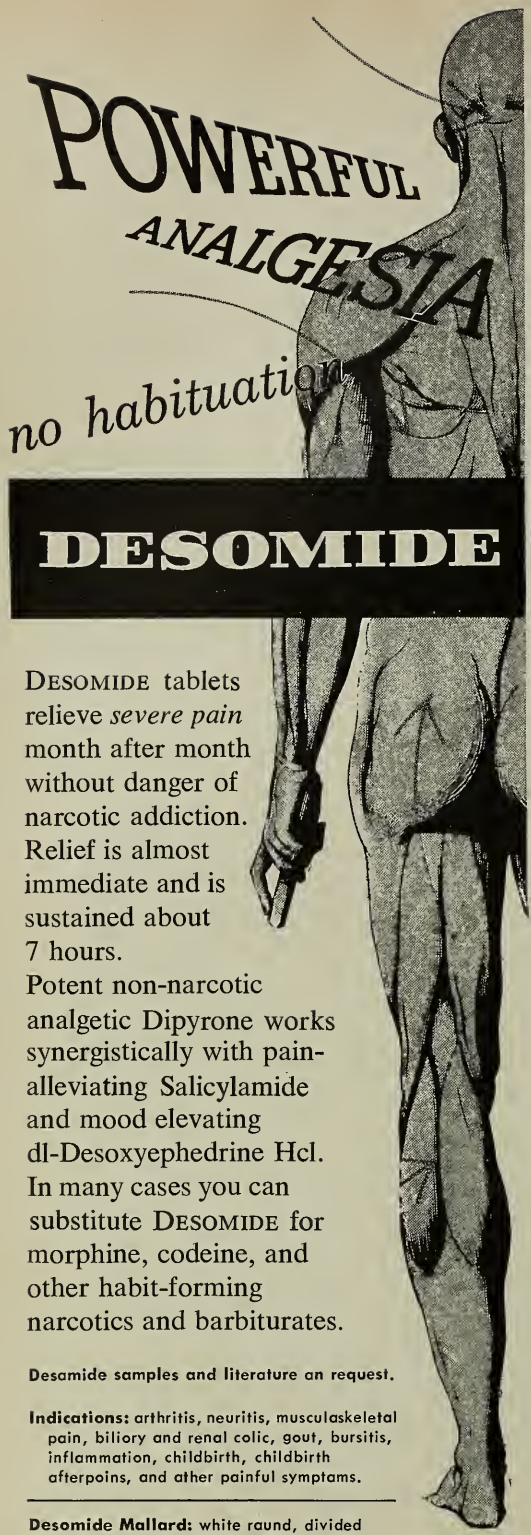
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## Trade union plans

In reeent years there have evolved many new plans for the distribution of and payment for medical care. Among these may be mentioned the various trades union health centers such as the Garment Workers' Center in New York; the plans wherein large groups of patients are treated by small groups of salaried physicians such as the Kaiser-Permanente Foundation; and the huge intercraft medical serviee plans involving millions of workers such as those eovering the United Steel Workers, the United Mine Workers, and the United Auto Workers. As Dr. Barton has pointed out, there is little doubt that these trades-union plans may powerfully influence future national health legislation, and also the conditions under which physieians must work. We eannot hope, nor is it necessarily desirable, to oppose completely these powerful trends. However, we certainly should examine their provisions carefully and use the full weight of our unified influence to the end that all changes will elearly be for the benefit of the reeipients of medieal eare, and will aeceptably fulfill all the reasonable requirements of those who must provide the care. Our own thriving Rhode Island Physieians Service Plan is a clearly sueeessful effort to provide needed assistance in the payment of medieal services. The younger members of our soeiety in partieular should give thought to these changing patterns of medical care, for it is their lives and work that will be longer affeeted. *Frank B. Cutts, M.D. A Unified Profession. Rhode Island M.J. June* 1956.

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Who is primarily affected by the plague of housing deeay? As in the case of tuberculosis, it is a plague of the people and not merely an afflietion of the health direetor or his department. We could never expeet to control tuberculosis without the understanding eo-operation of the publie. Tuberculosis services, case-finding programs, hospitals and sanatoria, rehabilitation services, finaneial aid for the patient and family, and the health department itself exist only because the publie believes in them as a means toward sueeess in the struggle against the tuberele bacillus.* Health edueation provides the thread that binds the program together so that failure is denied. Henry F. Vaughan, Dr. P. H., and Am. J. Pub. Health, Mar., 1956.



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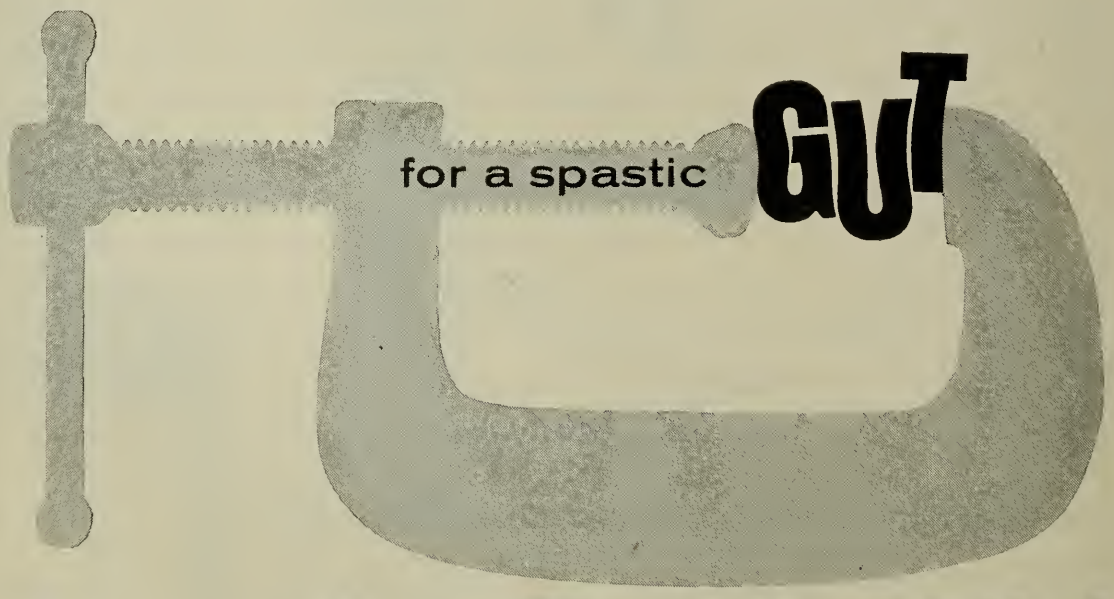
## Heparin and coronary thrombosis

At the Cardiac Clinic of the Cedars of Lebanon Hospital we have recently completed a controlled experiment on human subjects. Over 200 patients with known previous myocardial infarction were placed alternately in two groups. Each patient in one group received subcutaneously 200 mg. of concentrated aqueous heparin twice weekly, the minimum believed necessary to produce a substantially decreased average concentration of low density lipoproteins. Each patient in the control group received 1 cc. of isotonic saline twice a week. In all other respects, therapy was identical and fat restriction was not prescribed. Over a two year period, there were 21 cardiovascular fatalities among the controls and four in the heparin group. The observed difference in deaths, a ratio of 5:1, was statistically signifiant, $p<.01$. These results indicate that heparin, in the dose and manner administered, greatly retards the progress of cardiovascular degeneration in patients with coronary atherosclerosis. Hemorrhagic complications were infrequent and usually of minor importance, and there were no hemorrhagic fatalities although almost 20,000 heparin injections were administered. *Hyman Engelberg, M.D. The Prophylactic Management of Coronary Atherosclerosis. Geriatrics. June* 1956.

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## Accidents of children

Despite the fact that nearly all childhood accidents are preventable, the death rate from accidents among children is being reduced only about a third as fast as the death rate from disease. Before the accident problem can be solved it must be defined. It is best defined by statistics: From 11,000 to 13,000 children are killed by accidents in the United States each year; that is, one-third the total number of children who die each year do so as the result of accidents. From 40,000 to 50,000 is an estimate of the number of children permanently injured each year in the United States by accidents. Approximately 1,000,000 children receive medical care each year because of accidents. *Arthur C. Smid, M.D. and George B. Logan, M.D. Accidents of Children. Minnesota Med. June* 1956.


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1. Report of Study by Army, Navy, Air Force Motion Sickness Team: J.A.M.A. 160:755 (March 3) 1956.

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## Serum transaminase

Although pulmonary embolism may present a most variable picture and may be confused with a variety of clinical conditions, differentiation is perhaps most frequently necessary from myocardial infarction. In the present series, eight of 12 patients presented this problem. Myocardial infarction is almost invariably associated with elevation of serum transaminase levels since, in the experience of LaDue and Wroblewski, 297 of 300 patients with myocardial infarction manifested this elevation. Furthermore, these authors found the degree of elevation to be proportional to the extent of destruction of myocardial muscle. Therefore, a myocardial infarction extensive enough to result in a decreased cardiac output and clinical shock certainly should be accompanied by marked elevation of the level of serum transaminase. On the other hand, shock produced by pulmonary embolism, as encountered in five of our patients, was not associated with elevation of serum transaminase except in the patient who was jaundiced. Thus, the determination of the serum transaminase appears to be a valuable supplement to the electrocardiogram, which frequently is equivocal and open to diverse interpretations in such cases. *Frank Goldstein, M. D. et al. Use of Serum Transaminase Levels in the Differentiation of Pulmonary Embolism and Myocardial Infarction. New England J. Med. Apr.* 19, 1956.

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Even in terms of death rates from tuberculosis alone, the future task is large and prolonged. It will require years of effort to achieve a death rate of only 1.5 per 100,000 population, which is about the current death rate from acute rheumatic fever, appendicitis, arthritis, poliomyelitis, and several other diseases which are still considered to be of public health import. The maternal mortality rate is about at that level. Measles, whooping cough, and infectious hepatitis combined, do not exceed it. When the death rate from tuberculosis drops to the level of these important diseases, then tuberculosis control programs and needs should be re-examined. Robert J. Anderson, M.D., Pub. Health Rep., Feb., 1956.

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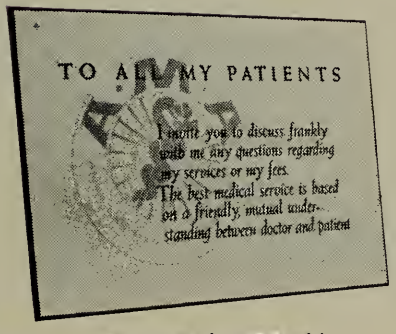
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## Never mind the diagnosis

Many years ago an upstate Vermont doctor who used to make rounds with his father told this story. One night, in the dead of winter, they were called out to see a woman who was "powerful sick." Let the younger doctor tell it. "We drove out and there was the woman in bed. My father listened to her lungs and took her temperature and said, 'Now, Mary, you take one of these pills every three hours in a third of a glass of warm water and you'll be all right.' Then he went out to the kitchen, put his feet on the table and said, casual like, 'Well, John, how's things?' 'Well, they ain't so good.' 'How's that?' 'One of my hosses is sick.' My father's feet hit the floor like a ton of bricks. 'Let me look at him.' He went out to the barn and looked in that hoss' eyes and his mouth; he listened to his heart and lungs; he felt of his belly and looked up his tail. Then he said, 'John, get me a quart bottle and my hoss medicines.' He mixed up a dose, pried that hoss' mouth open, and poured it down. 'Now, John,' he said, 'give that hoss all the water he wants but nothing to eat. He'll be all right in a day or so.'" Here, too, the Art of Medicine — and its versatility — are exemplified. *Henry Jackson, Jr., M.D. Sermons in Stones. New England J. Med. May* 10, 1956.

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## Premature death

Sudden death in young men from natural causes seldom is seriously considered; yet it occurs. It is particularly shocking when it strikes young men in the 17-20 age group. Relatives have a difficult time understanding why a young man, who recently left home in the best of health and was examined and accepted for military service, should die. This unpleasant explanation has had to be made 11 times in the past four years at this base. In most instances, the pathologic condition was beyond remedy or death occurred before any benefits from treatment could be expected. In five instances the diagnosis was suspected before death. In three cases the cause seemed clear at autopsy but in the remaining three, postmortem examinations did not give a completely satisfactory explanation. *James L. Tobin, M.D. Why Young Men Die. New York J. Med. July* 1, 1956.



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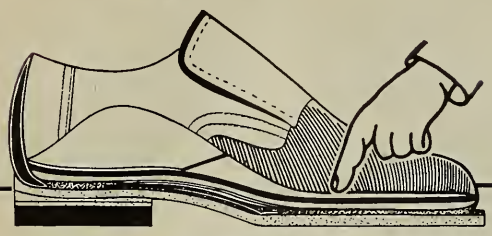
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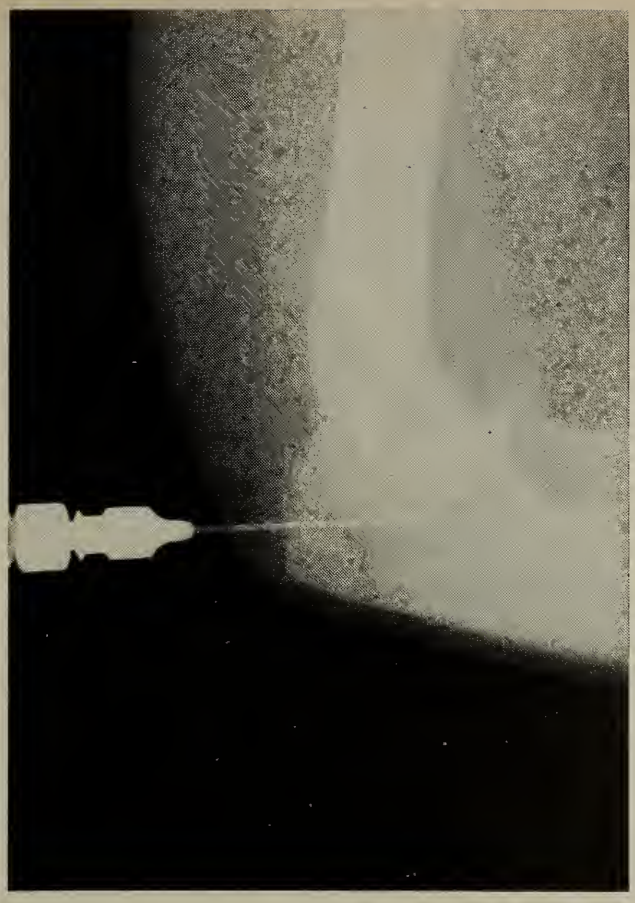
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## The adductor longus syndrome

The syndrome is worthy of mention mainly because of its confusion with osteoarthritis of the hip. The pain produced by the two diseases is quite similar and the differential diagnosis is made primarily by physical examination. The pain of the adductor longus syndrome is located in the medial thigh near the groin and/ or along the medial stretches of the inguinal ligament and its proximity. Pain radiates usually along the medial or anterior thigh superficially to the knee. It is increased by weight bearing or especially by sudden twists of the hip. It often is accompanied by a gelling phenomenon. The pain of degenerative arthritis of the hip usually is deeper in the groin and is more likely to be referred laterally than medially. If it is referred to the knee it is more often deep in the knee. The adductor longus trigger point is identified by tenderness at the origin of the adductor longus and in its upper three or four inches below the origin. The muscle is palpated easily as the major component of the adductor ridge along the medial, upper thigh. Treatment of the adductor longus syndrome combines injection with decreased weight bearing. The patient must be given crutches or a carefully graded walking program. Continued weight bearing will defeat or prolong the injection program; one twist of the hip can set treatment back to the beginning. Injection must be made deeply and carefully, beginning with the more tendinous portions of the muscle near its origin and infiltrating widely the belly of the muscle below the origin. This is one of the more gratifying myofascial pain syndromes to treat when isolated. However, it unfortunately occurs as a secondary finding in the presence of osteoarthritis, compounding the difficulty of diagnosis and partially frustrating treatment. Treatment is worthwhile nevertheless, even if there is underlying hip pathology. *Charles Long, II, M.D. Myofascial Pain Syndromes. Henry Ford Hosp. Med. Bull. June* 1956.

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We can no longer say that the development of home care programs is a future charge on health departments. The time is now. Leonard A. Scheele, M.D., Surgeon General, PHS, Pub. Health Rep., Jan., 1956.



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‹ ›

## The feed-back mechanism

The movements of the human body are nicely adjusted to their aim because there are sense organs in the limbs to provide information from joints and muscles. To use the fashionable terminology here, there is a feed-back mechanism to favor the action without allowing it to overshoot the mark. Movements undertaken by the social body to improve its health need the same kind of feed-back mechanism to control them. For measures concerned with physical health the feed-back is adequate because the evidence usually is plain enough — the table and graphs are there to support the conclusions — but the results of mental health measures are seldom as clearcut. Reports on them must be based much more on general impressions, and these will have little value unless they have been made by someone with a knowledge of mental hygiene and the time to study it. *Lord Adrian, M.D. Organizers of Health. Brit. M.J. May* 26, 1956.

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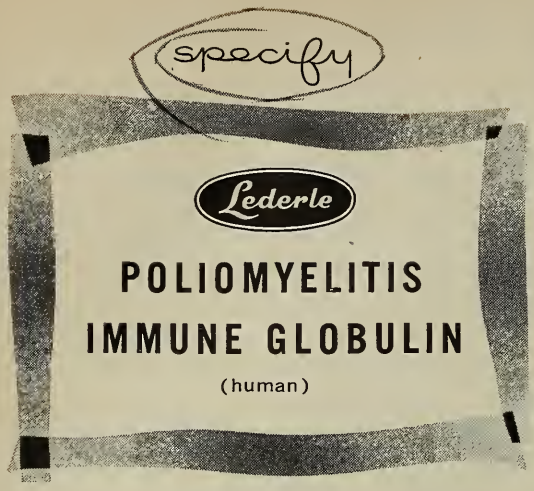
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## Syphilis today

Whatever reduction in the syphilis rate in this country has been achieved, has been due to two factors. The first is the organization and efficient functioning of venereal disease control activities throughout the United States. Here we see the effects of the funds expended by federal, state, and local governments in finding the contacts of persons with active syphilis and bringing them to treatment. Second is the effect of penicillin in rapidly reducing the infectiousness of syphilis and providing early and adequate cure. However, in spite of these funds and wonder drugs, the reported syphilis rate in the United States in 1953 was 100.8 per 100,000, whereas in 1919, without organization and without funds, the rate was 96.3 per 100,000. Recently the federal government drastically cut its budget and reduced the grants-in-aid for venereal disease control to the states and local communities. This was short-sighted economy. Many states and communities no longer provide epidemiological service in tracing contacts or persons with active syphilis. The authorities have lost sight of the fact that there is an infectious reservoir of venereal diseases still remaining in our communities. The sexual mores ofthe people being what they are, will further increase this reservoir. If control efforts are relaxed through overoptimism and penny-pinching, and if the present level of sexual promiscuity persists, one can predict epidemics of these diseases in the future. *John Godwin Downing, M.D. Syphilis in Industry. J. Am. M. Women's A. Nov.* 1955.

‹ ›

The development of tuberculosis in man is a biological struggle between the invasive powers of the agent and the resistance of the host, modified by a variety of environmental factors. In this country for nearly a century steadily declining mortality and morbidity, and more recently infection rates also, indicate that the balance for many decades has been in favor of the human host. Recent events in Europe rudely remind that this favorable trend is reversible. Equally sobering is the thought that in a number of the larger areas of the world tuberculosis is still the leading cause of death. Alton S. Pope, M.D., and John E. Gordon, M. D., Am. J. Med. Sciences. Sept., 1955.



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## Hormones and epilepsy

Steroid hormones, especially desoxycorticosterone, have been shown to have an effect upon epileptic seizures. This may be caused by the regulation of potassium concentration or by alteration of metabolism of the carbohydrate. Gonadal steroids also are important in the regulation of cerebral metabolism. In fact, Gordon and associates have postulated an alternative metabolic pathway from glucose-6-phosphate through phosphogluconate and pentose phosphate to pyruvate, which is thought to operate when certain steroids are lacking. The relationship of steroids to the electron transport system through the dehydrogenases and the cytochrome system also is shown. These factors would have only an indirect effect on epilepsy yet they might help to explain the fact that seizures sometimes first appear at puberty and often are related to the menstrual cycle. The pituitary hormone, ACTH, has been found to have extra-adrenal effects upon cerebral metabolism such as increasing the specific activity of phosphate or increasing the electrical activity of the brain as well as the concentration of acetylcholine and the ammonium ion in cerebral tissue. Hormones certainly are directly concerned with cerebral metabolism and probably are implicated in the actual production of epileptic seizures. *Eileen L. Ginter. Cerebral Chemistry and Convulsions. J. Am. M. Women's A. Nov.* 1955.

‹ ›

## Psychology

No one has specifically demonstrated any true hereditary aspects of immature behavior and I'm reminded of the story of the little boy who was about to be spanked. Just as the hairbrush was raised he said, "Stop!" Then he demanded of his father, "Did your Dad ever spank you?" The father, somewhat confused, replied, "Of course he did!" The little boy next said, "Did Great-Granddaddy ever spank Granddaddy?" The father said, "I guess so," and the little boy replied, "Dad, let's put an end to this hereditary brutality." *Douglas M. Kelley, M.D. Pediatricians, Psychiatrists, and Police. Texas J. Med. Dec.* 1955.

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A liberal is a man who is willing to spend somebody else's money.

— Carter Glass


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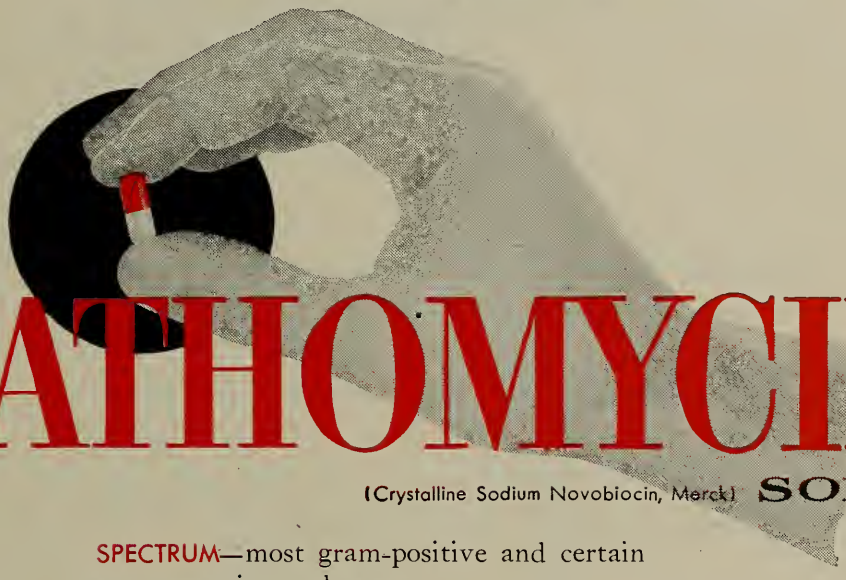
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## A common danger

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The great business of man is to improve his mind and govern his manners; all other projects and pursuits, whether in our power to compass or not, are only amusements.

— Pliny

## Thoughts on mental health

The psychiatrists, theologians, sociologists, and others who have participated in preliminary discussions for the past three years and whose efforts have culminated in the organization of the National Academy of Religion and Mental Health, deserve every acclaim for what they have done and for what they are setting out to do. No doubt, as their efforts become more and more integrated, their horizons will become even broader, and the scope of their accomplishments much more far reaching than is now apparent, possibly even to them. This organization is unique not only in this country but in the world. The idea of it has been about for a long time but the putting of these ideas and words into action is indeed most praiseworthy. One of the objectives, preventive mental health, has many ramifications. Not only the psychotic, neurotic, or hypochondriac person, the alcohol or narcotic addict, and the juvenile delinquent but also the normal man, woman, and child will benefit from this program. The board of trustees and the advisory council of the Academy present a most imposing array of names. Authorities in psychiatry, theology, sociology, cultural anthropology, and psychology are all there and the esprit de corps with which such an organization has been established for consultative and advisory services and for research in investigation of truth is tremendous. *Editorial. National Academy of Religion and Mental Health. New England J. Med. May* 3, 1956.

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If by magic we could eliminate today all new infections, we already have a stockpile of about 50,000,000 people in this country harboring live, virulent tubercle bacilli in their bodies. These individuals will produce a very substantial number of active cases of tuberculous disease year after year for decades to come unless some means are found to prevent such breakdowns or to destroy the tubercle bacilli now in their bodies. James E. Perkins, M.D., Managing Director, NTA, J. Lancet, April, 1956.

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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Send change of address on form 3579 to 1501 W. Washington Road, Mendota, Illinois.

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— Pliny

## Thoughts on mental health

The psychiatrists, theologians, sociologists, and others who have participated in preliminary discussions for the past three years and whose efforts have culminated in the organization of the National Academy of Religion and Mental Health, deserve every acclaim for what they have done and for what they are setting out to do. No doubt, as their efforts become more and more integrated, their horizons will become even broader, and the scope of their accomplishments much more far reaching than is now apparent, possibly even to them. This organization is unique not only in this country but in the world. The idea of it has been about for a long time but the putting of these ideas and words into action is indeed most praiseworthy. One of the objectives, preventive mental health, has many ramifications. Not only the psychotic, neurotic, or hypochondriac person, the alcohol or narcotic addict, and the juvenile delinquent but also the normal man, woman, and child will benefit from this program. The board of trustees and the advisory council of the Academy present a most imposing array of names. Authorities in psychiatry, theology, sociology, cultural anthropology, and psychology are all there and the esprit de corps with which such an organization has been established for consultative and advisory services and for research in investigation of truth is tremendous. *Editorial. National Academy of Religion and Mental Health. New England J. Med. May* 3, 1956.

‹ ›

If by magic we could eliminate today all new infections, we already have a stockpile of about 50,000,000 people in this country harboring live, virulent tubercle bacilli in their bodies. These individuals will produce a very substantial number of active cases of tuberculous disease year after year for decades to come unless some means are found to prevent such breakdowns or to destroy the tubercle bacilli now in their bodies. James E. Perkins, M.D., Managing Director, NTA, J. Lancet, April, 1956.

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September, 1956
Vol. 110, No. 3

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Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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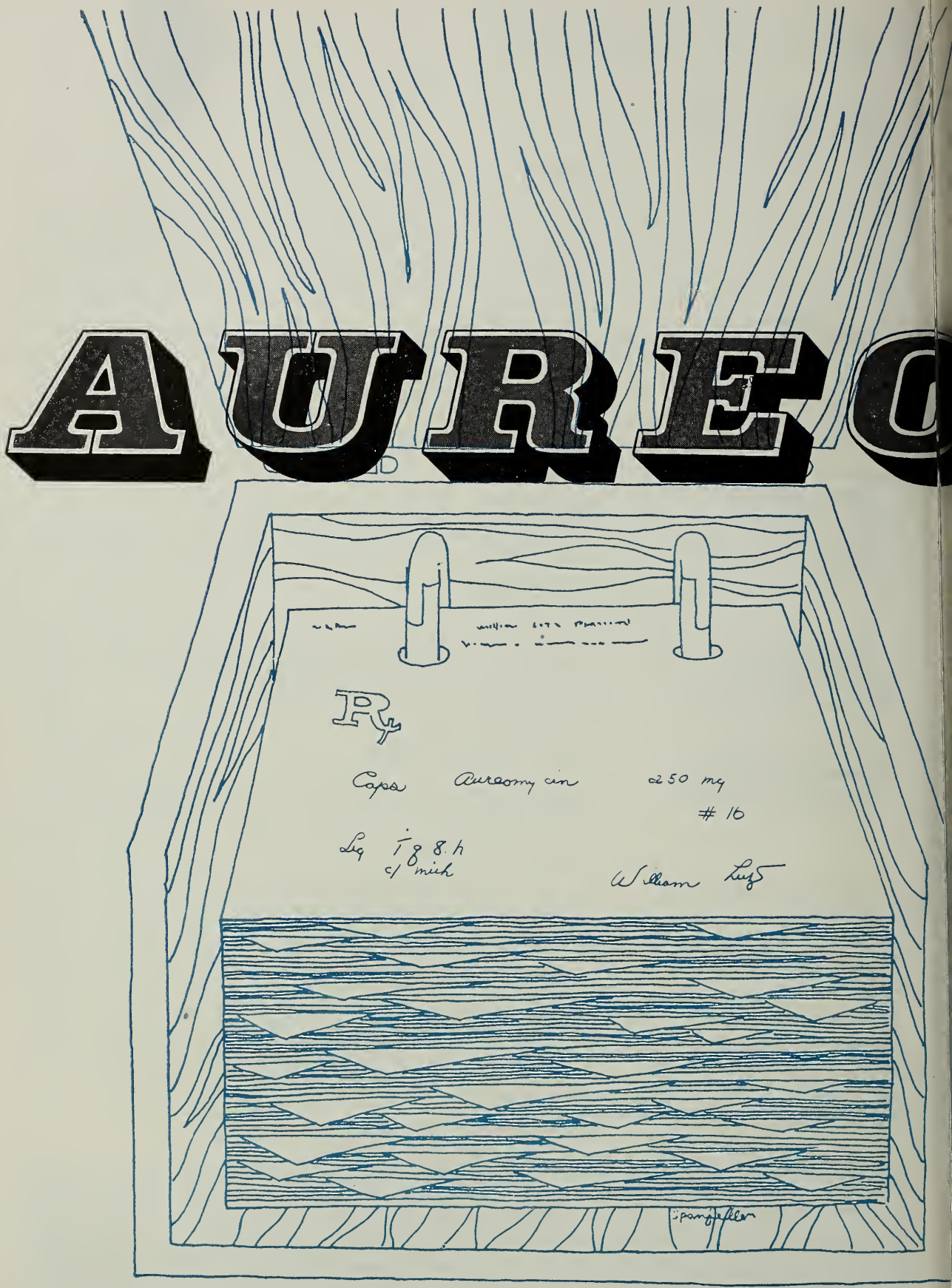
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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Send change of address on form 3579 to 1501 W. Washington Road, Mendota, Illinois.


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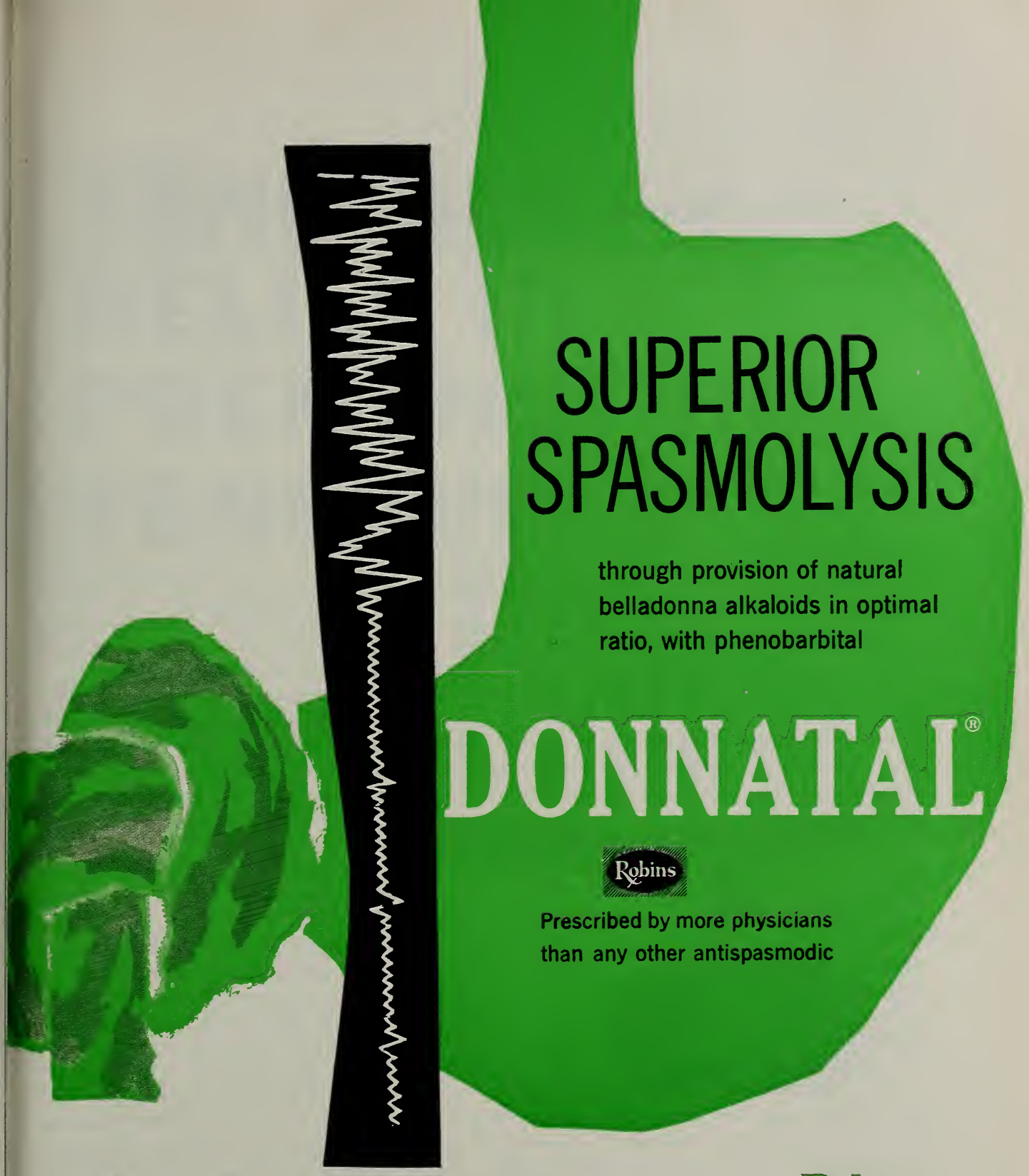
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# The Month in Washington



Washington, D. C. -- In terms of actual health bills passed and sums of money appropriated, the 84th Congress which ended just a few weeks in advance of party presidential conventions undoubtedly set some records. Measures ranged from the far-reaching program of disability cash payments to a bill for the commissioning of male nurses in the armed services.

In between are a wide variety of measures which, in the opinion of Secretary Folsom, Secretary of Health, Education, and Welfare, gives "promise of immediate and substantial progress on a wide front in the improvement of the nation's health."

Both Mr. Folsom and the President deplored the fact that Congress had not acted on their plan for federal aid to medical schools, but Congress decided this was one of the subjects that needed more study before taking any further action. In addition Mr. Folsom expressed disappointment that nothing had been done on authority for pooling arrangements among small health insurance companies and the long dormant plan for a health reinsurance fund.

On medical research funds, the administration this session asked for the largest amount of money ever requested in one year. The appropriation finally voted was even larger, some $170 million. On top of this, Congress in its final hours appropriated nearly $80 million to carry out new legislation just passed.

Here are the highlights of major health bills approved by the 84th Congress: Social Security Amendments — Changes in the 21-year-old social security law now include (1) Old Age and Survivors Insurance payments to disabled workers at age 50, paid from a "separate" fund, (2) extension of social security to some 250,000 dentists, lawyers, osteopaths and other self-employed persons, (3) lowering of retirement age for social security purposes for women from 65 to 62, (4) earmarked payments for medical care of public assistance recipients, and (5) increase of payroll deductions by one half of 1% and three-eights of 1% for the self-employed.

Laboratory Research Facilities — The Hill-Bridges bill for $90 million in construction grants over three years to public and nonprofit institutions to erect research facilities started out in the Senate as a bill to aid research in crippling and killing diseases but wound up for research in all "sciences related to health."

Health Amendments Act — The so-called little omnibus health bill provides for federal grants for training of public health specialists, professional nurses qualified for teaching and administrative jobs and for practical nurses — plus a two-year extension beyond next July 1 of the 10-year-old Hill-Burton hospital program, and special projects grants for mental health studies and demonstrations.

Medical Care for Military Dependents — A long sought goal of the Defense Department was enactment of a permanent program of medical care for dependents of armed services personnel either in military hospitals and clinics or through private sources. It is scheduled to begin early in December.

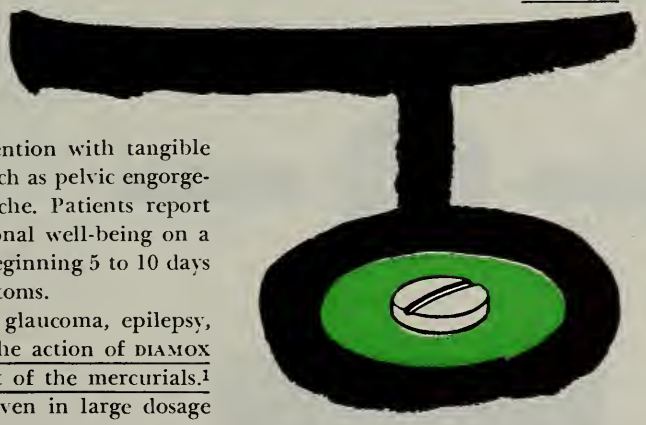
National Library of Medicine — Another proposal long in the making was the reestablishment of the Armed Forces Medical Library as the National Library of Medicine. For administrative purposes, Congress put it under the

(*Continued on page* 34)

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1 Krantz, J. C. and Carr, C. J.: The Pharmacologic Principles of Medical Practice. Ed. 3. The Williams & Wilkins Co., Baltimore, 1954, p. 1011.

2 Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics. Ed. 2. The Macmillan Co., New York, 1955, p. 856.

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**WASHINGTON (Continued)**

Department of HEW, but left up to the 17-man board of regents the selection of site — in all likelihood in the Washington area.

Sickness Survey — Special and continuing surveys on the extent of illness and disability in the U. S., along with medical care being offered have been authorized — the first detailed study of its kind in over 20 years. The work will be done by the Public Health Service.

Water Pollution Control — The PHS is authorized to make grants to states and communities to help in construction of sewage disposal plants, at the rate of $50 million a year for 10 years.

Some other measures signed into law by the President were: establishment of a mental health program for Alaska, budget increases for additional staff for the Food and Drug Administration along with a new headquarters building for modern laboratories; provision of medical care for employees and dependents of the State Department abroad in U. S. military facilities; a $400,000 fund to finance the holding of the World Health Assembly in this country in 1958 (which is the 10th anniversary of the founding of the World Health Organization); and the commissioning in the armed services of osteopaths.

**NOTES**

The new surgeon general of the PHS is Dr. Leroy E. Burney, a career officer in the commissioned corps and for 10 years commissioner of health for the state of Indiana. Until his nomiation by the President he was deputy chief of the PHS Bureau of State Services. Dr. Burney received his medical degree from Indiana University.

The federal government withdrew from the allocation of the Salk poliomyelitis vaccine just 15 months after the first release of the vaccine, but federal grants to states to help finance inoculation programs continue.

In preparation for a national blood bank directory, the Joint Blood Council with headquarters in Washington launched a nation-wide survey September 1 of all blood banks.

< >

The aim of education should be to convert the mind into a living fountain and not a reservoir. That which is filled by merely pumping in will be emptied by pumping out.— John M. Mason

The
ILLINOIS
Medical Journal
Official Journal of The Illinois State Medical Society

SEPTEMBER, 1956
VOL. 110 NO. 3

# The Non-Surgical Treatment of Comitant Strabismus

HERMANN M. BURIAN, M.D., IOWA CITY, IOWA

THE rational management of any condition presupposes a knowledge of the causes and of the physio-pathology underlying that condition. In the case of comitant strabismus we are very much in the dark about both cause and physio-pathology, but certain things are known.

We know that in comitant strabismus there is a misalignment of the visual axes of the eyes. And we know that this misalignment is accompanied by well defined signs and symptoms. Outstanding among these are the prevalence of certain types of refractive errors in definite types of strabismus, reduced visual acuity in one eye, poor or absent binocular co-operation owing to suppression or anomalous retinal correspondence, and abnormalities in the motility of the eyes.

I am not proposing to discuss in this paper the etiology of comitant strabismus and I leave the question wide open to what extent these various signs and symptoms are cause or consequence of the strabismus. Everyone is entitled to his own views in this complicated field. But it is of practical significance that we be acquainted with these signs and symptoms and it is necessary for us to realize that there are both innervational and non-innervational factors involved in almost every case of strabismus.

It is most important that we be aware of this, for we must always keep in mind that surgical treatment can effect a change only in mechanical conditions: a change in the position of the eyeballs, and a change in the effectiveness of the ocular muscles. Innervational factors are influenced by surgery only indirectly, insofar as a change in the relative position of the eyes may secondarily produce a change in the binocular co-operation. But surgery is the only means by which a permanent change is the relative position of the eyes can be achieved.

Non-surgical treatment, on the other hand, can only indirectly affect the relative position of the eyes, by altering the impulses reaching the extra-ocular muscles. This change is, however, not necessarily permanent. Thus a child may have perfectly straight eyes while wearing glasses, but not without the glasses and while exerting accommodation. Or, a patient with exotropia may have been taught by orthoptic training to keep his eyes straight, but as soon as he relaxes the compensatory convergence impulse, his exotropia may again be manifest.

---

*From the Department of Ophthalmology, College of Medicine, State University of Iowa, Iowa City, Iowa*

*Read before the Eye, Ear, Nose and Throat Section of the 115th Annual Meeting of the Illinois State Medical Society, May 17, 1955.*

Innervational and mechanical factors are not present in the same proportion in all cases of strabismus. One must determine to what extent innervational and non-innervational factors are the responsible agents in each particular case. This is one of the reasons why non-surgical treatment should always precede surgery in every case of squint.

Before entering upon the discussion of the non-surgical treatment of strabismus, I wish to answer one general question. When should the treatment of the child with strabismus be started? The answer to this question can be only one: as soon as the strabismus is discovered. The ophthalmologist may not have the opportunity to see the child at that moment. Parents are not always very observing; they often prefer to delude themselves into thinking that such a thing could not happen to their child. Often they also only too willingly listen to well-meaning relatives and friends who advise them to wait before taking the child to a doctor, since the child will doubtless outgrow the squint. Unfortunately, there still are pediatricians who offer the same advice, coupled with the remark that the ophthalmologists cannot do anything for the child at an early age and that it is wiser to wait until the child grows older and more co-operative. Here there is a wide field for ophthalmologists to spread enlightenment. No child is too young to have his strabismus treated in one way or another. To be sure, not all forms of treatment are appropriate for children of all ages, but some form of treatment can be instituted with beneficial result at any age.

## TREATMENT BY GLASSES

It has been recognized for a long time that the first important step in the diagnosis and treatment of all forms of concomitant strabismus is the determination of the refraction of the patient's eyes and the wearing of an appropriate correction. The great Dutch physiologist and ophthalmologist, Donders, established over 100 years ago the close relationship between accommodation and convergence on the one hand and uncorrected refractive errors and accommodation on the other hand and thus laid the foundation for the treatment of strabismus by glasses, more especially for the treatment of concomitant convergent strabismus by corrections for hypermetropia.

I shall not linger over the theoretical aspects of the problems but shall only discuss the practical consequences of Donder's teaching.

Every patient with any kind of concomitant strabismus must first of all be refracted and must be given appropriate glasses to wear for a certain period of time.

How should he be refracted? The method depends to some extent on the training and preference of the ophthalmologist, but there is, I believe, general agreement that in children under 10 or 12 years of age, refraction in full atropine cycloplegia is indispensable. In older children refraction in homatropine cycloplegia may be used and in adults one may employ whatever method one has found to give the best results in one's hands.

What are "appropriate" glasses? Should one prescribe for the patient the full correction found in atropine cycloplegia, thus correcting for both the latent and manifest hypermetropia, or should one make allowance for the cycloplegia? There is no unanimity on this point. Some authors are very emphatic that one should give the full atropine correction; others, I believe the majority, correct only the manifest error.

In my own experience the system which seems to have worked out best is based on the following considerations. We wish to give the patient the maximum correction which is consistent with a reasonable use of the eyes. A reasonable use of the eyes is a relative concept which differs greatly in accordance with the age of the patient. The younger the child, the more likely he is to tolerate a correction which may tend to blur his distant vision. It is obvious why this should be so. The world of a small child is restricted to a narrow compass, to the things "near at hand." Distant objects have no meaning, for one thing because of the child's relatively low visual acuity; for another, because he is not ready to "grasp" objects which are at some distance away. Every ophthalmologist of some experience knows how much more difficult it is to make a young child fixate at twenty feet than at twenty inches. But as the child grows his horizon enlarges and distance vision becomes increasingly important. By the time he goes to school he should have glasses which insure maximum vision at distance. Only thus will the child be able to work comfortably and successfully in

school. If the glasses reduce the vision, the child will soon find it out and either look over the glasses or dispense with them altogether, regardless of parents and doctors. It has always been my belief that it is preferable that the child wear a correction of, say, + 2.75 D. than to have a correction of, say, + 3.50 D. which is kept in a drawer.

Another point which I wish to make concerns the minimum amount of hypermetropic correction which should be given to a child. Some ophthalmologists think that hypermetropic corrections of from + 1.00 to + 1.50 D. cannot influence the angle of squint and that it is useless to prescribe such corrections. I disagree with this. In some cases low corrections have a remarkably great effect on the angle of deviation. This again, can be readily understood. Children with a high degree of hypermetropia have to exert so great an accommodative effort in order to see clearly that they often prefer blurred vision to the strain caused by the attempt to accommodate, whereas patients with lower degrees of hypermetropia constantly exert their accommodation and are often of the spastic or hyperkinetic type. The wearing of glasses produces, therefore, not rarely a much more dramatic effect than would seem to be commensurate with their power.

In some patients the wearing of glasses — either weak or strong — reduces the angle of squint to zero for both distance and near fixation, and such patients may spontaneously regain binocular vision. These are said to have accommodative strabismus. In others, the wearing of glasses causes no modification in the angle of squint or reduces it only partially. We then conclude that the strabismus in these patients is not, or only in part, of the accommodative type. In a number of patients the wearing of the refractive correction fully reduces the angle of squint for distance, but not for near fixation. In these patients it is advisable to test the effect on the angle of squint for near vision of an additional + 1.50, +2.00, +2.50 D. or + 3.00 D.o.u. over the distance correction. If the measurements show that this additional correction produces a significant reduction in the angle of squint at near, the patient should be given bifocals.

The prescription of bifocals makes it possible for such a child to keep his eyes straight in near vision. By having his eyes in proper alignment in the all-important near vision range, the child may keep or regain binocular co-operation. This advantage of the bifocals overshadows any disadvantage which such glasses may have. Theoretically there is no objection to them and practically speaking children generally do not react unfavorably to the wearing of bifocals. Actually, they get used to them more easily than do some adults and they will use their bifocal segment, if a large enough segment is provided. This segment can be cemented on for ready removal. Any difficulties which the child's parents may make can be overcome by pointing out to them that bifocals for children are a temporary measure comparable to some types of exercises.

While we are in general in favor of as high a correction for the refractive error as a patient will wear, there are certain exceptions to this rule. In a child with accommodative strabismus who has worn his correction for some years, one may decide to reduce the hypermetropic correction in an effort to assist the orthoptic treatment which is intended eventually to enable the child to dispense altogether with the glasses at least for distance vision. Also, in some cases of exophoria or exotropia one may decide to give the patient an over-correction for his myopia in order to stimulate his accommodation and through this to stimulate his convergence.

A type of spectacle which aims not at the correction of the accommodation-convergence relationship, but at offsetting the angle of squint are spectacles which incorporate prisms. Some ophthalmologists believe that patients can be made to wear prisms of as much as 20 or 30 prism diopters and that if prisms which just undercorrect the angle of squint are incorporated in the glasses and worn for a certain length of time, this will create favorable conditions for fusion. Theoretically the use of strong prisms at an early age should be beneficial, but to my knowledge this procedure is not used routinely.

The use of prisms after the angle of squint has been reduced by surgery is much more widespread. This is, without doubt, a useful adjunct in our therapeutic armamentarium. Vertical prisms are especially helpful. There are patients who are unable to regain binocular vision after surgery even with the use of post-operative orthoptic treatment, in whom the re-establishment of fusion and normal binocular vision is con-

siderably facilitated when vertical prisms are incorporated in the glasses.

Lastly, there is the question, how long should a patient wear his glasses before decisions are made regarding other forms of therapy, especially surgical therapy? In many patients the effect of the glasses is quite obvious from the very start. As soon as the glasses are placed in front of his eyes the angle of squint is materially reduced. However, the accommodation-convergence relationship is not immediately stabilized and one should give this relationship a chance to become fully adapted to the conditions created by the wearing of the glasses. One should, therefore, allow the patient to wear his glasses for at least one or two months before deciding about the effect of the glasses on the relative position of the patient's eyes and his binocular cooperation. This statement only relates to the ordinary spectacle corrections. Special glasses, bifocals, glasses with prisms, etc., must be worn for 3 to 6 months or longer before the therapeutic result can be fully assessed.

## TREATMENT BY DRUGS

Accommodation, and through accommodation the accommodation-convergence relationship, can also be influenced by drugs. There are two ways in which this can be achieved: either by making accommodation impossible or by making it unnecessary.

To prevent accommodation some ophthalmologists choose to prescribe for their patients — especially for very young children — atropinization of both eyes for a period of months or years, making up for the patient's lack of accommodation by giving them bifocals. Good results are claimed for this method. I have no personal experience with it.

Atropinization inhibits the contraction of the ciliary muscle but does not stop the accommodative effort. Experienced opthalmologists know that incomplete atropinization may actually increase the angle of squint in estropia because of an excessive accommodative effort exerted by the patients. It has, therefore, been suggested that miotics rather than cycloplegic drugs be used in the treatment of accommodative esotropia. Such use is based on the consideration that these drugs produce an accommodative spasm by stimulating peripheral nervous structures, thus obviating the need for an accommodative impulse which in turn would give rise to over-convergence. The idea is ingenious and it can indeed be shown that children with purely accommodative esotropia are enabled to keep their eyes straight following instillation of pilocarpine or better, DFP. It remains to be seen whether the treatment with miotics can lead to a cure within a few months, and whether binocular vision gained during this period is maintained after the use of the drug has been stopped. The prolonged use of DFP leads frequently to the formation of cysts at the pupillary border of the iris, but these apparently disappear completely after the instillations are discontinued.

## OCCLUSION

The proper optical correction is the firm basis for any treatment of a patient with comitant strabismus. But one must not lose sight of the fact that refractive errors alone never result in a manifest strabismus. Other factors have to contribute to produce a misalignment of the optical axes of the two eyes.

These factors are obstacles occurring in the motor or sensory part of the visual apparatus and insofar as it is possible these must be investigated and treated in every case of strabismus.

One of the major symptoms in comitant strabismus is the well-known condition of amblyopia ex anopsia in which the vision of the habitually deviated eye is reduced to a greater or lesser extent, without there being visible evidence of pathologic changes in the eye.

Regardless of one's thoughts concerning the origin of this condition, the experience of the past 25 years has clearly shown that there is an effective remedy for true amblyopia ex anopsia. The patient must be made to use his amblyopic eye, and he will regain in the course of time a good deal of acuity in that eye.

The most effective way to make the patient use his ambyopic eye is to prevent him from using his normal, fixating eye. This can best be achieved by patching that eye completely and constantly for a certain period of time. The child is then forced to use the amblyopic eye.

This would not seem to be a complicated procedure, but in the practical application of this simple method of treatment a number of questions and difficulties arise which must be discussed.

I have emphasized that occlusion should be

complete and constant. Occluding the better eye for an hour or two a day is rarely if ever of any avail. Now, occlusion is by no means as innocuous as it may appear to be. It is not only unpleasant for the child, particularly if the vision of the amblyopic eye is low. It also entails a transferring of dominance to a thoroughly non-dominant eye and this has at times far-reaching effects on the nervous system. The children may become nervous and hard to handle. On a number of occasions, I have observed that children begin to stammer whenever they are occluded or vice versa, but less frequently, that stammerers begin to talk normally when occlusion is instituted. Nevertheless, in view of the beneficial effect of occlusion on visual acuity, it is the duty of the ophthalmologist to attempt it in every case of amblyopia ex anopsia. But he must make it plain to the parents that the period of initial difficulties has to be overcome if they wish their child to regain better vision in the amblyopic eye. Unless the occlusion is carried out in accordance with the directions given by the ophthalmologist, it is a useless torture for both the child and the parents.

Eyes can be occluded in various ways. One can use an occluder which fits in one way or another to the spectacles which the child is wearing. If such an occluder is used it must be properly adjusted, particularly on the nasal side, since children have an amazing capability of peeking through small cracks between occluder and skin. A better type of occluder is one which is fastened to the skin by means of adhesive tape. Such an occluder can be easily make up of cardboard or elastoplast or else a commercial occluding patch may be employed. While the direct application of such a patch is the best assurance against peeking, it is often not possible to use this kind of occluder for a prolonged period of time, if the child has a sensitive skin. It is best to vary the difficult kinds of occluders in accordance with the needs and circumstances, alternating between occluders which attach to the glasses and occluders which fasten to the skin.

When occlusion is first prescribed, it is, in my opinion, essential that the ophthalmologist see the child within two or three weeks from the beginning of the occlusion. It is quite wrong to let a child go for a period of weeks or months without checking up on the occlusion and its effects. There are a number of reasons for this. At first the occlusion is often not carried out properly. The parents, usually the mother, have many questions which come up during the time occlusion is tried. In order to shorten the procedure it is wise to see the patients within two weeks or so after the beginning of occlusion to check up on their progress. Another, most important point is this. In my experience, if the occlusion is carried out properly, there is in the majority of cases a marked improvement during the first two or three weeks, if the eye will improve at all. It is of interest both to the ophthalmologist to find out how the child has reacted to the occlusion and of help to the morale of the patient and the parents if one can show that the visual acuity as improved by occlusion.

How long should one occlude the better eye? This cannot be stated in absolute figures, but there is general agreement that the better eye should be occluded until the vision in the amblyopic eye has been brought up to normal or at least to the level of the better eye, if this eye does not have full visual acuity. How long this process may take depends on many factors. It depends on the age of the patient, it depends on his adaptability, it depends on the thoroughness with which the occlusion has been carried out, it depends on the visual acuity which was present at the beginning of the occlusion and on other less obvious factors. As I have pointed out before, occlusion improves the acuity in most cases rather rapidly at the beginning of the treatment. Once a good beginning has been made it is relatively easy to reach a certain level, say 20/50, 20/40 or 20/30. After this the process is usually much slower. I find it as a rule much harder to improve the vision in a child from 20/30 or 20/40 to 20/20 than to bring it from 20/100 to 20/30 or 20/40.

No general rule of the thumb can be laid down as to how long an eye should be occluded. Children with a very high amblyopia do not always react to occlusion with a rapid initial improvement in visual acuity. It may take two or three months before their very poor visual acuity is improved to the point where one can see hope for further improvement. I feel, that if the vision has not improved at all after a period of two or three months, there is little likelihood that the vision will improve with continued occlusion. One has then to consider

that these eyes have pathologic changes which are not visible by the ophthalmoscope but which prevent the eye from regaining vision.

It has been suggested of recent years that in cases of very high amblyopia, especially in so-called eccentric fixation, an initial total or partial (temporal) occlusion of the amblyopic eye is helpful in breaking up undesirable habits and in assisting in establishing visual acuity in that eye. My personal experience with this form of treatment is too limited to permit me to assess its value, but reliable observers have reported good results.

Both the ophthalmologists and the parents are at times disturbed by the fact that on occasion the vision of the occluded eye decreases as the vision of the amblyopic eye improves. Together with this there usually goes a transformation of the previously unilateral strabismus into an alternating strabismus.

I am in the habit of congratulating the parents when this occurs. A rapid increase in visual acuity of the amblyopic eye, together with a slight decrease in the occluded eye, is to my mind a good sign. It indicates that the child is still pliable and that with proper handling of the case good vision in both eyes can be eventually insured. But this occurrence is an added reason why I feel that children who are treated by occlusion, should frequently be seen by the ophthalmologist or by the orthoptist to check up on their progress.

A much more serious occurrence from the standpoint of the parents is the appearance of a heterotropia, a manifest or constant strabismus, as a result of occlusion. In some children who show no strabismus or only an intermittent heterotropia, occlusion is apt to produce a constant deviation. This is a happening which we can well explain, but it is easier to explain it to ourselves than to the parents. Some ophthalmologists warn strongly against occluding in cases in which the eyes are more or less straight, for fear of producing a heterotropia in the child and unpleasantness for themselves.

I don't hold with this point of view. I believe, that it is the duty of the ophthalmologist to point out to the parent that the vision of the eye of their child can be improved. It is the first and foremost task of the ophthalmologist to do everything in his power to obtain maximum visual acuity in the eyes of his patients. But he must also warn beforehand the parents or the patient that a heterotropia may result. If he explains the situation properly to the parents, they will, as a rule, take the chance.

Occlusion may also bring out a latent nystagmus but nystagmus as such is not a contraindication to occlusion. I have seen a number of cases in which a nystagmus would disappear during the course of treatment and with the improvement of the visual acuity.

The last, and a very important question is: At what age should occlusion be started and up to what age is occlusion effective?

There really is no lower age limit. It is, of course, impossible to determine the visual acuity of infants with any degree of accuracy, but if an infant's eye is constantly deviated, this is presumptive evidence that the eye is, or will be, amblyopic. It is also obvious that occlusion is the more effective, the younger the child is. But it is difficult to patch an infant's eye. The infant may not object as much as the parents. In infants, and for that matter in any child in whom total occlusion is not feasible, one may resort to the partial occlusion afforded by atropinization of the fixating eye. Partial or total occlusion can thus be instituted at any age. But what about the upper age limit?

My views on this point are as follows. I don't believe that there really is an upper age limit at which occlusion is no longer effective. To be sure, the younger the child, the easier and quicker one can achieve an improvement in its visual acuity. But in a true amblyopia ex anopsia vision can be restored at almost any age. Numerous instances are recorded in the literature in which adults, even in their 50's and 60's regained vision in the amblyopic eye following the loss of their better eye.

The limitations of age are not so much a matter of physiology as a matter of motivation. If the motivation is present, the vision of the amblyopic eye can be improved at almost any age.

To the young child the motivation comes from the outside. He obeys — more or less willingly — and does what he is told by doctor and parents. As a child grows older, there comes a time when he will no longer accept parental orders unhesitatingly. Unless a young person wants for some specific reason to have his vi-

sion improved, it will be almost impossible to make him accept occlusion. The teen-ager is very sensitive about his appearance; he is much too busy in school and outdoors, competing with the other children scholastically and on the playing field, to bother with occlusion. Once teen-age is over and the exigencies of existence make themselves increasingly felt, there can no longer be any question of amblyopic treatment. The only motive strong enough to make an adult use the amblyopic eye is the loss of the better one and this motivation has proven to be sufficient for the restoration of reasonably good vision at any age.

It must finally be emphasized that a number of ophthalmologists of wide experience have noted that if occlusion is begun after the age of 8 or 10 years, the acuity of the amblyopic eye may indeed increase but this result is not permanent. When occlusion is stopped the vision will gradually slip back unless binocular vision is achieved. Such slipping back is, of course, not noted if the fixating eye had been lost.

## TREATMENT OF AMBLYOPIA BY EXERCISES

While occlusion is a most effective form of treating amblyopia, it still is a passive method of treatment. Occlusion of the better eye in itself will not improve the visual acuity of the amblyopic eye. Only the use of the amblyopic eye will help improve its visual acuity. It is of the utmost importance not only to have the patient occlude the better eye, but to insist that he use his amblyopic eye.

This can be done in various ways. One may either, after explaining the situation clearly to the mother, ask her to let the child watch television, look a books, make little drawings, do some needle work, let the child watch moving pictures, and the like. In other words, one must ask the mother to encourage the child to use the eye. A better way is to plan exercises for the child in accordance with the age and the development of the child. The exercises should always be stimulating and arouse the interest of the child. Treatment by exercises, as opposed to treatment by occlusion, is emphasized by some authors and is carried out in consequence and on a large scale in some centers, especially the treatment of eyes with eccentric fixation. Whether the effort expended will prove to be worth while in terms of results superior to the ones obtained with the more conventional methods remains to be seen.

## ORTHOPTIC TREATMENT

Occlusion is not only a most effective means of improving the visual acuity of the amblyopic eye. It is also used extensively as an orthoptic procedure to combat suppression and it is one of the most effective weapons in the treatment of abnormal correspondence.

This brings us to the important question of orthoptic treatment.

I shall not discuss the general problem of the value of orthoptic exercises in the various types of neuromuscular anomalies of the eyes or the details of the technique. We are here specifically concerned with the problem of treatment of comitant strabismus, and this discussion will be restricted to the orthoptic treatment of this type of neuromuscular anomaly.

If the goal of treatment is a functional rather than a cosmetic cure, then surgery alone will in the majority of cases not suffice to achieve it. Surgery has to be supplemented by non-surgical treatment. The essence of this non-surgical, orthoptic treatment consists in combating the sensory obstacles to binocular vision.

Patients with comitant strabismus, that is with a misalignment of their visual axes, present in addition to this deviation — which can be designated as a motor defect — a number of sensory defects such as amblyopia ex anopsia, suppression and anomalous correspondence. These defects must be removed to achieve a functional cure.

If surgical or non-surgical means or both have been successful in overcoming suppression and in restoring retinal correspondence to normal, then an attempt may be made to improve the binocular co-operation further by giving the patient that essential latitude which is afforded by fusional movements. If one succeeds in this, then the patient will frequently also attain stereopsis.

In general, then, orthoptic exercises attempt to give the patient good fixation and good vision in each eye; they are to rid him of abnormal suppression and of abnormal retinal correspondence and they are to restore fusional movements and with it normal binocular co-operation. In some patients it is possible to do this without resorting to surgery; in others surgery has

to be added. Finally, in a large number neither surgical correction of the deviation nor added orthoptic exercises will restore proper binocular co-operation to the patient.

In days past it has been taken for granted that a good cosmetic result is all that the ophthalmologist should attempt to achieve. With increasing understanding of the physiologic processes behind strabismus and with improved techniques of orthoptic training, the conviction has become more and more widespread that the purely cosmetic result is not the ideal goal of our therapeutic measures. I doubt that there is today an ophthalmoloigst who would not pay at least lip service to the tenet that the goal in the treatment of strabismus should be a functional one as well as a cosmetic one.

Nevertheless, as ever broadening experience is gathered in orthoptic treatment, many questions have arisen in the minds of the ophthalmologists with regard to the value of this difficult and costly form of therapy. Not only the effectiveness of the treatment itself is being questioned. The question is raised, is it really of such paramount importance to give a patient binocular vision to warrant the great expenditure of effort and money involved in orthoptic training? If the answer to this question is yes, in that single binocular vision is very important in today's struggle for living, then how many patients with strabismus under proper treatment will achieve single binocular vision with a good degree of stereopsis? If single binocular vision is not essential in the struggle for life, then is it essential to insure a good surgical result in the majority of cases? And if the answer to this is yes, should the treatment by exercises be given preoperatively or postoperatively or both? Should one, considering the answers to all these questions, routinely use fusion training or other orthoptic measures as part of the treatment regardless of the nature of the deviation?

These are some of the questions which are frequently asked. I believe that, if they were presented to a forum of competent ophthalmologists, very divergent answers would be received. I shall attempt to give in the following briefly my own point of view.

Orthoptic treatment is undoubtedly beneficial and has an important place in the treatment of strabismus. It is directed against sensory and innervational factors in comitant strabismus as are all other forms of non-surgical treatment. In patients in whom these factors are the prevalent cause of the strabismus, orthoptic training can in itself constitute sufficient treatment of such a patient. It is possible, for instance, by means of orthoptic training to teach a child who is hypermetropic and has a purely accommodative strabismus, to dissociate accommodation from convergence. Such a child will be enabled to keep his eyes straight without resorting to the use of glasses. If the binocular co-operation in such a child is further strengthened by fusion training, the child may be for practical purposes "cured" of his strabismus.

Such a result is, however, possible only in cases in which a certain amount of binocular co-operation existed to begin with. In the majority of patients with concomitant strabismus the binocular co-operation is at a minimum and non-innervational factors are at work which in themselves are not amenable to orthoptic treatment.

Such patients may have their eye properly aligned by surgery. This constitutes a cure of the misalingment, but it is only a cosmetic correction. The question is, should an attempt at restoration of binocular vision be made in these difficult cases?

Binocular vision is undoubtedly a desirable goal. In many occupations good binocular vision is an asset which enables the person to be better equipped to compete with his fellow workers. On the other hand, an individual that has never experienced the advantage of binocular vision is as a rule quite well adapted to his deficiency and is well able to perform tasks which require a high degree of visuo-manual co-ordination. He is without question much better off than someone who has inadequate binocular vision. This consideration must be weighed before orthoptic exercises are instituted in a patient with the intent of giving him binocular vision.

I do not wish to convey the impression that I am unduly pessimistic with regard to orthoptic exercises. I believe that they are very valuable indeed. But they should be used with discretion. Not every case which may be amenable to orthoptic treatment must also be so treated. Indiscriminate routine use of fusion training is not desirable.

Obviously, all cases should be given orthoptic

treatment in which it may reasonably be expected that exercises may influence beneficially the manifest deviation. The same holds true especially for all cases of latent deviations in which exercises may rid the patient of symptoms. If it is neither a matter of reducing a deviation or giving comfort, but a matter of establishing binocular co-operation, judgment should be exerted in the selection of cases. It may be the part of wisdom — for social as well as medical reasons — to leave some patients alone and to rest content with a cosmetic surgical result.

Nor should orthoptic treatment be instituted in the belief that abnormal sensory conditions affect the surgical result adversely. Preoperative orthoptic treatment is doubtless desirable, but I have never been able to prove to my own satisfaction, except in cases of eccentric fixation, that the failure of an operation was due to the presence of sensory anomalies, say to an abnormal correspondence. To be sure, the surgical result is best if the patient has or regains binocular vision. This transforms the heterotropic patient into an heterophoric individual and such an individual, by definition, keeps his eyes straight. But this is not to say that the sensory status of the patient as such endangers the result of an operation.

It seems to me that ideally every patient with comitant strabismus who comes to the attention of an ophthalmologist should have an orthoptic evaluation. This orthoptic evaluation will tell the opthalmologist whether or not the conditions are favorable for orthoptic training and whether or not orthoptic training would seem to be desirable. If training is indicated, then the patient should have pre- and postoperative treatment, if operation is needed. The preoperative treatment should be carried out to the point at which in the opinion of the orthoptist and the ophthalmologist the treatment has yielded the maximum benefit which can be expected. The postoperative treatment should begin as soon as possible after surgery, preferably within a matter of days.

## CONCLUSIONS

While there may be a question about the need and the advisability of orthoptic treatment in cases of non-innervational comitant strabismus, there can be no question about the need for some of the other non-surgical procedures which have been discussed. There can be no question about the need for early and thorough correction of the refractive error, and there can be no question about the need for insuring good fixation, both in distance and near vision, and maximum visual acuity in either eye. It is desirable, insofar as it is possible, to transform every case of uniocular strabismus into a case of alternating strabismus with good visual acuity, good fixation, and a minimum of suppression in each eye, before surgical treatment is undertaken. If it is possible to do away with an abnormal retinal correspondence and in addition to establish some fusion at the objective angle, this is all to the good.

But one must not expect the impossible. One must not expect non-surgical treatment to remove permanently an angle of squint of non-innervational origin. This is where the surgical treatment comes in.

University Hospitals

# The Surgical Indications in Duodenal Ulcer

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THE role of surgery in the treatment of duodenal ulcer is one of many complexities. Its evaluation by many groups throughout the years has evolved into an accumulated number of facts and data concerning the diagnosis, treatment, morbidity and mortality. The literature abounds with conflicting data, and statistics regarding successful treatment in the duodenal ulcer problem. This fact alone proves the many variables which exist. I think we will all agree that no two ulcer patients are exactly alike.

At the Cook County Hospital a very definite step forward in the surgical treatment of duodenal ulcer has been made in recent years. As the operative mortality has decreased, the surgical indications have increased in favor. These indications are directed not toward the duodenal ulcer per se, but only to the ulcer which has gone on to some major complication.

We consider, in general, four such complications: perforation, hemorrhage, obstruction and intractable pain. The problem of malignancy here is, of course, negligible.

The first complication to be considered is that of perforation. Duodenal ulcers are known to perforate in 2 to 3 per cent of all ulcer patients.[1] This may be the first sign of a duodenal ulcer, although the majority of patients have had symptoms anywhere from several days to many years. It usually occurs between the ages of 25 and 45 years, but may occur at any age. The symptoms and signs of perforation are well known.

The indication for early surgery here is obvious. This consists of closure of the perforation and aspiration of the gastric spillage from the subphrenic spaces, colon gutters and pelvis. We prefer a free omental graft for closure of the hole.

The results of the above surgery are excellent, with a mortality rate in our hospital of 2.1 per cent as compared with a 15.8 per cent mortality in patients treated conservatively.[2] The latter group were, for the most part, patients misdiagnosed early, or were admitted late to the hospital for treatment.

There are two main objections to conservative management. One is that there is no way to determine the size of the perforation or adequacy of the sealing off process until very late, and the other is the prevention of secondary abdominal abscesses by removal of the gastric spillage.

The time interval between perforation and treatment is extremely important. Most patients enter a hospital within two to three hours after perforation, and are operated before twelve hours have elapsed. In cases of delayed hospital admission, no time limit should be adhered to as a criterion for surgical versus nonsurgical treatment. If the abdominal findings are localized, then management should follow that outlined by Ochsner for peritonitis. If improvement is not steady, or there is evidence of increasing peritonitis, then surgery becomes necessary, and is associated with a higher mortality.

Once the patient has recovered from a perforation, there are two questions to be answered. One is, "What are the probabilities as to future ulcer trouble?" and, secondly, "What complications are most likely to develop?" Clairmont and William Mayo used to teach that once an ulcer perforated, the patient was cured.[3] It is now known that the patient cannot be given an absolute clean bill of health. On the contrary, it can be prognosticated that approximately one-third of all patients with perforations will remain well without any treatment whatsoever,

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*Presented at a Session of the Chicago Chapter, American College of Surgeons, January* 19, 1956.

one-third must be maintained on medical management, and one-third will eventually need definitive surgery for their duodenal ulcer.[4]

Work done at the Cook County Hospital answers the second question concerning complications.[5] (Slide) This represents 237 patients with previous ulcer perforations who presented themselves to the hospital for treatment of one of the major ulcer complications. Intractable pain was the leading complication with 86 per cent, followed by bleeding in 34 per cent, obstruction in 21 per cent, and reperforation in 17 per cent.

The last group was of extreme interest, as one patient had reperforated on five different occasions. The time intervals between perforations was noted to be extremely variable. In one case the patient went 28 years before his ulcer again perforated.

A unique perforation is the so-called "Forme Fruste" type. This responds well to conservative methods, but usually goes on to some complication requiring surgery.

The second complication is that of hemorrhage. (I will merely mention this important complication, as it has been discussed in detail in the first presentation.) Again, this complication may be the first sign of a duodenal ulcer. The majority of ulcer bleeding is in small, intermittent episodes from superficial erosions. However, 20 to 25 per cent of all ulcers bleed massively at one time.[6]

The indication for surgery here, above all, conforms to the principles of proper timing. That is, in massive hemorrhage, with a debilitated patient, a situation is created which may change hourly. All the facts must be correlated and surgical intervention attempted at the most opportune moment.

The third complication is obstruction. Gastric retention, with associated vomiting, secondary to an active duodenal ulcer, occurs rather frequently. However, true organic obstruction is not a common sequelae. These two types of obstruction must be differentiated.

The first is a physiological obstruction which is, in fact, a pyloric obstruction, and is due to a combination of factors leading to persistent vomiting. These are attributed to reflexes from an active ulcer, local edema, motor disorders of the pyloric ring, and reversed peristalsis.

The second is organic obstruction, and follows chronic ulcer activity, especially of large posterior ulcers. Eventually this leads to a scarring and contraction of the duodenum. This cicatrix, in contrast to the first type, is a true duodenal obstruction.

Diagnosis of organic from physiological obstruction is mandatory, as this delineates the surgical from nonsurgical patients. Three procedures are done concomitantly: 1. The initial treatment of all cases is instituted. 2. Diagnosis is made while viewing the results of treatment. 3. Patients who are needful of surgery are being properly prepared without loss of time.

Treatment is divided into three phases. The initial phase consists of stomach rest with nothing by mouth; continuous nasogastric suction; sedation with barbiturates; intravenous fluids, electrolytes, and proteins; and finally, whole blood.

The second or intermediate phase is slow dietary progression from oral liquids to a soft, bland diet.

The final phase consists of a strict ulcer regimen. A barium meal or motor meal, if one prefers, is done to re-evaluate the amount of retention, and to scrutinize the ulcer characteristics. Lastly, surgery is indicated in those patients with persistent obstruction.

A rather simple and inexpensive test for gastric retention that may be carried out at any time during the course of the treatment is a pyloric balance study. This consists of introducing a measured amount of glucose solution into the Levin tube and clamping it off. If, at the end of one hour, little fluid is aspirated, then the obstruction is considered relieved. Should the amount injected and removed be identical, the obstruction is partial. If more fluid is removed than injected, the obstruction is almost complete.

Approximately three-quarters of all obstructions open up with this treatment. These patients are then to be treated medically, but may go on to recurrence or to other complications. Those that remain obstructed are operated only after the patient has been returned to the best nutritional state possible. Hypoproteinemia, anemia and alkalosis are corrected, and a positive nitrogen balance is considered essential.

The fourth and last complication is pain. Before a patient is subjected to surgery for in-

tractable ulcer pain, every effort should be made to see that proper medical management existed beforehand. Medical care does not mean only sedation, antacids, antispasmodics and strict dietary regimn, but investigation and help in the patient's economic, social and psychological background as well. It may be added that very young patients with pain as the only complication of ulcer should be maintained on medical management as long as possible. Many of these ulcers will heal spontaneously at a later date when the stress situations have changed.

Duodenal ulcers with severe pain indicating necessary surgery are oftentimes penetrating. The common site is into the pancreas, posteriorly, and may be associated with some degree of pancreatitis. This is the type of patient depicted as "typical" of the ulcer diathesis with pain, anorexia, weight loss, nausea, vomiting and malnutrition.

I would like to point out that of the four complications of duodenal ulcer discussed, the first three are quite obviously objective. This last complication of pain is subjective, and quite certainly taints the statistics in both the surgical and medical treatment of ulcer.

## SUMMARY

1. In summary, perforation, hemorrhage, obstruction, and intractable pain constitute the major complications of duodenal ulcer.

2. The surgical indications of these complications have been discussed.

3. No attempt was made to indicate the best surgical procedure for any one complication except acute perforation.

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## Manual of standard therapeutic diets

The Commission on Nutrition of the State Medical Society is now making available a new revised edition of its MANUAL OF STANDARD THERAPEUTIC DIETS. The first edition, issued several years ago, proved so popular that supplies were soon exhausted.

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A new concept is emerging of the kinds of services and facilities that will be required for comprehensive care of the chronically ill, the disabled, and the aged. This concept recognizes the need for a wide variety of services and facilities, but the emphasis is on prevention and rehabilitation. The patient is viewed as a person in his home in his own community where he will receive the greatest part of his care under the supervision of his personal physician. The community remains the central factor in any plan for his care. Leonard A. Scheele, M.D., Surgeon Gen., PHS., Pub. Health Rep., Jan., 1956.

# The Recognition of Streptococcal Infections in the Prevention of Rheumatic Fever and Acute Glomerular Nephritis

ALAN C. SIEGEL, M.D., WINNETKA

THE physician who sees a child or young adult with an acute upper respiratory illness must differentiate, by clinical or laboratory means, between a viral and a bacterial infection, and then must treat judiciously with a specific antimicrobial agent, if indicated. The commonest bacterial agent implicated in upper respiratory infections is the Group A streptococcus. Infections due to this organism are of primary concern because of the development of non-suppurative complications such as acute glomerunephritis and acute rheumatic fever in a certain percentage of untreated patients.

The importance of streptococcal infections is further emphasized by the controlled studies of Wannamaker and Rammelkamp and members of the Streptococcal Disease Laboratory in Cheyenne, Wyoming, which showed that effective antibiotic treatment of the preceding streptococcal infection will prevent the subsequent development of acute rheumatic fever and acute nephritis. We ought to do everything in our power to diagnose streptococcal infections carefully and accurately and to give adequate treatment to all patients and contacts in whom the organism has been isolated.

This paper will discuss the difficulties encountered in the diagnosis of streptococcal infection in children, and will point out certain simple and accurate methods to facilitate diagnosis. It also will relate the public health aspects of streptococcal infections to the family and the need for a liaison between the public health physician and the practitioner in the control of streptococcal infections.

During the preceding 14 months my associate, Dr. George Eisenberg, and I have had an opportunity to observe 729 children, ranging respiratory infections. All were acutely ill and had a temperature of 101 degrees F. or more in age from 2 to 14 years, with acute upper during the period of observation.

Considerable discussion had arisen between us concerning the diagnosis of bacterial infections and their differentiation from viral infections. Each of us had an idea as to what a "strep throat" looked like; myself, from membership in the Streptococcal Disease Laboratory in Wyoming during the previous two years, where I had the opportunity to observe young adults with proved classical streptococcal infections. My associate had observed children during 20 years of practice and felt he could tell what a strep infection looked like.

Our mutual concept of a classical strep throat is shown in Table 1 and follows closely the criteria set up by the committee of the American Heart Association. Classical hemolytic streptococcal infection of the respiratory tract is a febrile illness, usually of acute onset, and as-

Table 1.
Signs and Symptoms of Acute Streptococcal Infections

| *Common Symptoms* | *Common Signs* |
|---|---|
| 1. Sore throat | 1. Red throat |
| 2. Headache | 2. Exudate |
| 3. Fever 101 to 104° | 3. Swollen glands |
| 4. Abdominal pain | 4. Rash |
| 5. Nausea and vomiting | 5. Acute otitis, sinusitis |

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*Presented before the Joint Meeting of the Section on Preventive Medicine and Public Health and Section on Pediatrics, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1955.*

sociated with chills, headache, malaise, and a variable degree of prostration. The characteristic symptom is severe sore throat. Cough and coryza occasionally are pressent but are not prominent complaints. Horseness is rare. Several observers have shown that redness and edema of the pharyngeal tissues and tender anterior cervical glands appear in only 60% of streptococcal infections. A review of 100 patients entering the hospital with acute rheumatic fever in whom either cultural or immunologic evidence of a recent untreated streptococcal infection was found would show that 60 would give a history of classical strep throat; 20-30 would remember a recent cold or scratchy throat; 20 would have no recollection of any recent upper respiratory infection. Rantz has shown the variable picture of streptococcal disease in children at various age groups especially under age 6 and has emphasized that a "runny nose or red throat without exudate may be an acute streptococcal infection in this age group".

This 40% represents a sizable portion of missed cases and an attempt has been made by us to pick these cases out of the population. Through the cooperation of Dr. Herbert Miller, Health Officer of our village community, we obtained sheep's blood agar plates and sterile cotton swabs. An incubator was installed in our office. Throat cultures were obtained on all 729 patients at the time of initial observation. We swabbed the posterior pharynx and tonsillar area and the cultures were swabbed directly on the blood agar plates within two hours, and were streaked out with a wire loop and incubated overnight. As you can see, it is relatively simple to pick out the beta hemolytic colonies from other saprophytes or nonpathogens such as the alpha or green strep. Sheep's blood is a selective medium which allows only the beta hemolytic streptococcus and the staphylococcus to produce complete hemolysis; the latter is easily distinguished from the former. This method was used to distinguish macroscopically in a rapid and simple manner between the presence and absence of B.H.S. in the throats of the 729 patients.

At the time of throat culture, each of us made a notation of our diagnostic impression of the patient's illness. These have been grouped into 3 classifications. Table 2.

Table 2.

| | |
|---|---|
| I | Classical strep throat or scarlet fever |
| II | Questionable Strep Inf. |
| | A. Sore throat |
| | B. Swollen glands |
| | C. Red pharynx and tonsils |
| III | Non-streptococcal Inf. |
| | A. URI |
| | B. Grippe |
| | C. Cold |

*Category* I: Classical streptococcal infection as I have described and including scarlet fever.

*Category* II: Questionable streptococcal infection. As you will note, this group includes children with clinical signs and symptoms of definite sore throat and occasionally accompanying acute otitis or sinusitis. Symptoms such as malaise, fever, and headache were common. All patients had red or inflamed pharynx or tonsils but none had exudate. Many patients had tender anterior cervical glands.

*Category* III: Nonstreptococcal infections includes those patients with symptoms and signs of upper respiratory infection not localized, such as hoarseness, coryza, swollen glands, or malaise. We would commonly feel that these patients had either URI or the grippe. They did not have severe sore throat or symptoms referable to the pharynx or tonsillar area.

Follow-up cultures were obtained on approximately 40% of patients with positive cultures 14 to 21 days after the initial visit. Recurrences were noted and cultured. In all instances of positive cultures the number of B.H.S. colonies on the blood plate were enumerated and classified from 10 colonies per plate, a one plus culture to pure cultures or B.H.S., a four plus culture. Approximately 75% of the positive cultures were three to four plus. Half of these were sent to the Streptococcal Disease Laboratory in Wyoming for grouping and typing to confirm the presence of a pathogenic streptococcus. Ninety per cent were Group A, therefore, pathogenic; 10% were other groups, of questionable importance.

Table 3 depicts the correlation between our initial diagnostic impression and the presence of Group A streptococci. Thirty per cent of the 729 children were found to harbor beta hemolytic streptococci. Of these 224 children,

Table 3.

DIAGNOSIS VS CULTURAL RESULTS

| Diagnostic Class. | Pos. Hem. No. | Beta Strep. % | Neg. Hem. No. | Beta Strep. % |
|---|---|---|---|---|
| I | 125 | 71 | 51 | 29 |
| II | 66 | 42 | 88 | 58 |
| III | 33 | 9 | 366 | 91 |
| Total | 224 | 30 | 505 | 70 |

125, or 55% were diagnosed as classical strep throat or scarlet fever, 66, or 21% were classified as questionable strep infection, and the remaining positive cultures were seen among children with URI; grippe, or a cold. This would mean that 76% of streptococcal infections would manifest the symptoms and signs of sore throat, scarlet fever, tonsillar exudate, or swollen anterior cervical glands. However, when one considers the number of times these diagnoses were made in the absence of beta hemolytic streptococci, one notes that 29% of the patients in Category I were negative and 58% of our patients in Category II were not streptococcal. This means that we are correct 70% of the time, using classical criteria but wrong 60% of the time calling sore or red throats alone, strep throats.

Thus one cannot use the second classification accurately to diagnose streptococcal disease in children. The dilemma arises, however, when one considers the 40% of these children with positive cultures in Category II. This group cannot be neglected because this 40% probably represents missed cases which ultimately are susceptible to nonsuppartue complications. On the other hand, is it fair or good medicine to give antibiotics to the other 60% with negative cultures because they have sore or red throat and fever? We have come to rely upon throat cultures and frequently delay specific therapy 24 hours in Group II to ascertain the presence or absence of streptococci.

The question of whether patients harboring Group A streptococci may have been incidental carriers is difficult to answer. We did not obtain leucocyte counts on more than 10% of these patients. Catanzaro and Rammelkamp have emphasized the importance of the persistence of streptococci in the patient who develops rheumatic fever. In addition, the human carrier is important as a mode of spread of streptococcal disease in the community and eradication serves to reduce rheumatic fever in the community.

The clinical course of streptococcal versus nonstreptococcal infections was difficult to ascertain since almost all patients with positive cultures received antibiotic therapy. It is our impression that the clinical course was shortened in these children, although Wannamaker and Denny have shown by controlled observations that the clinical course of treated and untreated streptococcal infections, barring suppurative complications, is virtually the same. No children in either group developed acute rheumatic fever or acute nephritis, although both complications have occurred in the community during the same time period.

The school age child as a prime in the family has received attention from Kemp and Dingle. These observers feel that infections begin in the family as a result of their introduction by the school age child. In streptococcal infections or scarlet fever, many physicians institute prophylaxis with sulfa or penicillin to other members of the family. We have had the opportunity to obtain throat culture on members of 43 families of children with streptococcal infection or scarlet fever.

In Table 4 one notes that 32 of 153 persons, or 20% harbored beta hemolytic steptococci in their throats on examination.

Table 4.
Incidence of Beta Hem. Streptococci
Among Family Contacts

| Tot. No. Cult. | Tot. Fam. Cult. | B.H.S. Pos. | B.H.S. Neg. |
|---|---|---|---|
| 153 | 43 | 32 | 121 |
| Percent of Total | | 20 | 80 |

In order to determine whether the school age sibling was a primary family infector, the families were further studied from the point of view of duration of symptoms in the patient.

In Table 5 when symptoms have been present in the school aged child 24 hours or less, the incidence of positive family cultures is sharply reduced. This would suggest that prophylaxis or throat cultures should be instituted only if the patient has been sick over 24 hours.

It is felt that the throat culture offers a simple and effective means of detecting beta hemolytic streptococci in children with bacterial upper

Table 5.
Incidence of Beta Hemolytic Streptococci Among Family Contacts According To Duration of Illness in Patient

| Duration of Illness in Patient | Families | Contacts: Pos. | Neg. |
|---|---|---|---|
| 24 hrs. or less | 22 | 1 | 67 |
| Over 24 hrs. | 21 | 31 | 54 |
| TOTAL | 43 | 32 | 121 |

respiratory infections. The actual cost of material in each blood agar plate is 8c to 10c. Either the hospital laboratory may be induced to make these for a nominal cost or the services of a clinical laboratory may be engaged to furnish them. A survey of five laboratories on the north side of Chicago reveals a cost of from 15c to 25c per plate. We found that within a month our nurses could learn to streak and read plates under our supervision with considerable accuracy.

## SUMMARY

Methods have been presented to facilitate the recognition of streptococcal infections. It is felt that these methods will make clinical medicine more precise and more gratifying and will aid in the adequate treatment of these infections. In addition, the relationship between the clinical case and the family has been presented to thus extend the role of the clinician as an epidemiologist in the ultimate prevention of acute rheumatic fever and nephritis.

## Septal spur

During the past four years I have seen, operated upon, and made a follow-up study of 21 patients suffering cephalagia which resembled Sluder's sphenopalatine ganglion syndrome. These patients had, as the only disclosed etiology, a visible spur or ridge of the nasal septum, which contacted or impinged on the opposite lateral nasal wall or structures, innervated by sensory peripheral branches of the fifth cranial nerve and the automatic nervous system. *Harry L. Cunin, M.D., Septal Spur Cephalagia. Pennsylvania M. J. April* 1956.

Physicians and organized medicine are rightfully if a little tardily assuming a more active role in health education. Health forums sponsored by local medical societies have served a most useful purpose, including the demonstration that the physicians of a community can work together and pool their efforts in a common cause. Hospitals need to take a more active part in health officers. L. E. Burney, M.D., Calif. Med., Jan., 1956.

# Oxytetracycline–Hydrocortisone Ointment in Pediatric Dermatoses

M. B. Andelman, M.D., and L. A. Nathan, M.D., Chicago

SINCE their introduction, the sulfonamides and antibiotics have been used successfully, both topically and systemically, in a wide variety of skin disorders. But their success has been mitigated by their high sensitizing potential. Similarly, the adrenal cortical steroids, cortisone and hydrocortisone, have found extensive application in dermatologic practice, but their systemic use has been limited by the possibility of serious adverse effects. It has been shown that systemic hormonal effects need not be feared when hydrocortisone is administered by local inunction in dermatoses[1] because of the apparently complete absence of systemic absorption from the skin[2]. It has been demonstrated also that of the several so-called broad-spectrum antibiotics oxytetracycline (Terramycin®), topically applied, does not evoke any sensitization to its subsequent systemic use.[3]

Hydrocortisone, which is now thought to be the principal glucosteroid hormone normally secreted by the adrenal cortex,[4] has been effective when used topically in infantile eczema[5,6] atopic dermatitis, contact dermatitis, and anal and genital pruritus although symptoms frequently return on withdrawing the therapy.[1,7-12] Oxytetracycline topically applied is of value in impetiginous and other primary skin infections and also in the eradication of secondary pyogenic infections which frequently exacerbate underlying dermatoses.[13,14]

Topical preparations combining both these agents together may be used with satisfactory results in various dermatoses.[10,15] They are without antagonistic effect upon each other and the suggestion has been made[10] that in certain cases they may be synergistic in combination. The safety and efficacy of this combination in a topical ointment suggest a wide field of use in pediatric practice. The present study was undertaken to evaluate this combination in a variety of common pediatric dermatoses.

## MATERIALS AND METHODS

An ointment combining oxytetracycline and hydrocortisone* was used in treating 50 pediatric patients. A few had primary pyodermatoses, while the majority had dermatoses complicated by or potentially susceptible to secondary pyogenic infection. The children ranged in age from 5 weeks to 15 years and all were treated two, three or four times daily with Terra-Cortril Topical Ointment®. Treatment was continued until the lesions were cleared or showed no further improvement. In no case was treatment continued longer than two weeks; in most cases three or four days was sufficient to evoke the full therapeutic effect of the ointment. During the interval no other medication was given.

## RESULTS

The results are shown in the following table:

| Diagnosis | Number of Cases | Results of Treatment Exc. | Good | Fair | No Imp. |
|---|---|---|---|---|---|
| Diaper dermatitis | 15 | 2 | 12 | 1 | — |
| Atopic and eczematoid dermatitis | 6 | 1 | 1 | 4 | — |
| Impetigo | 5 | 1 | 4 | — | — |
| Urticaria | 4 | 1 | 2 | 1 | — |
| Burns (2nd deg.) | 2 | — | 2 | — | — |
| Infected lacerations | 3 | — | 3 | — | — |
| Intertrigo | 2 | — | 2 | — | — |
| Insect bites | 2 | — | — | 2 | — |
| Allergic blepharitis | 1 | — | 1 | — | — |
| Paronychia | 1 | — | 1 | — | — |
| Molluscum contagiosum | 1 | — | 1 | — | — |
| Poison oak rash | 1 | — | — | 1 | — |
| Psoriasis | 1 | — | — | 1 | — |
| Infected thumb | 1 | — | — | 1 | — |
| Varicella | 1 | — | — | 1 | — |
| Varicelliform eruption | 1 | — | — | 1 | — |
| Neurodermatitis | 1 | — | — | 1 | — |
| Measles | 1 | — | — | — | 1 |
| Ringworm | 1 | — | — | — | 1 |

*Terra-Cortril Topical Ointment, containing 3 per cent oxytetracycline hydrochloride (Terramycin Hydrochloride) and 1 per cent hydrocortisone (Cortil) in petrolatum, was supplied for this study by Dr. M. William Amster of Chas. Pfizer & Co., Inc., Brooklyn, New York.

*Excellent* indicates complete remission of dermatosis within a week. *Good* indicates marked improvement. *Fair* indicates relief of pruritus and/or objective improvement only while the treatment was continued.

All 15 cases of diaper dermatitis responded to treatment. Two cases were cleared completely in less than four days. Symptoms recurred in only one on stopping the treatment. While diaper dermatitis is generally self-limiting, we are impressed with the speed and efficacy of the treatment.

There was improvement in all six cases of eczema, all five cases with impetiginous involvement, and all cases of urticaria, intertrigo, infected lacerations, and burns. One case each of several other disorders was permanently improved, as tabulated.

In a number of other dermatoses, improvement was seen as long as treatment was continued, usually with relief of pruritus, but no permanent results were obtained. Symptoms of the underlying conditions recurred on withdrawing treatment. This was true in four cases of eczema, although two others were benefited permanently. Temporary relief was obtained in two children treated for insect bites, and one case each of several allergic and other inflammations. There was no improvement in the one case each of measles and ringworm.

## SUMMARY AND CONCLUSIONS

Fifty cases of skin disorders common in children have been treated by local inunction with Terra-Cortril ointment; 48 (96 per cent) showed improvement under this therapy, and in no case was there an adverse reaction to the treatment.

Both the acute histamine-like reactions and the more chronic eczematoid conditions common in pediatric cases showed a rapid clinical response. In cases involving secondary infection the ointment was both supportive and therapeutic, as observed in several cases of complicated diaper dermatitis. This result is in agreement with earlier studies on oxytetracycline and hydrocortisone administered independently. The speed with which pruritus and inflammation subsided in acute dermatoses is of particular interest.

The preparation used in this study is an effective therapeutic agent for pediatric inflammatory dermatoses where secondary infection has developed, and as a prophylactic agent when secondary infection is likely to develop.

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# Nasal Fractures: Diagnosis and Management

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TODAY's stress on increased mechanization, power, and speed places more responsibility on the medical profession toward the management and treatment of nasal fractures. The nose, because of its facial prominence, is readily susseptible to injuries and nasal bones are broken more often than any other bones of the face.

The external nose is partly bony and partly cartilaginous. The upper bony part consists of paired nasal bones which articulate with processes from the frontal and maxillary bones. They articulate above with the nasal part of the frontal bones and laterally with the frontal processes of the maxilla. The lower part of the nasal pyramid is largely cartilaginous and usually is described as being formed by five major cartilages and a variable number of smaller ones. The major cartilages are the two upper lateral cartilages (triangular) above; the two lower lateral (greater alar) below; and the median unpaired septal cartilage (quadrangular). The upper lateral cartilages are continuous with each other across the midline and also with the septal cartilage. It frequently is described as a single cartilage and is called the nasal septal cartilage. The lower nasal cartilages, or greater alar cartilages, consist of a medial and lateral crus. The medial crura form the columella. The lateral crura give shape to the ala, and it is these cartilages which bind and hold open the nasal apertures.

The nasal septum is formed by the perpendicular plate of the ethmoid posteriorly and the septal cartilage anteriorly. The vomer forms the postero-inferior portion of the septum, while the medial crura of the lower lateral cartilage (greater alar) and the low nasal process (crest) of the maxilla complete the septum anteriorly.

## FACTORS PRODUCING FRACTURES

The direction, force, and traumatizing object determines the line of displacement. A blow to the side of the nose may result in a simple fracture on one nasal bone. It may include the frontal process of the maxilla causing depression of one side of the nose, or the entire bony arch may be dislocated from its attachment at the base and deviated to one side. A direct blow over the bridge of the nose may fracture the frail inferior edge of the nasal bone. If the impact occurs at a higher level, the nasal frontal articulation may be separated. This is unusual.

A recent survey of 190 nasal fractures at the Manhattan Eye, Ear & Nose Hospital revealed that 80% of the fractures occurred at the junction of the thick upper with the thin lower portion of the nasal bones. The junction between the thick and thin portion varies in different individuals and appears to be the determining factor in the level of the fracture.

Injuries or dislocations of the septal cartilage may be associated with fractures of the nasal bones or may occur independently. When the nose is struck by a blow against the tip and columella, the septal cartilage may be forced upward against the perpendicular plate of the ethmoid. The septal cartilage may be fractured along a vertical line just anterior to the vomer, or along a horizontal line parallel to the vomer. The cartilage can be dislocated from its vomerine groove and from the crest and the nasal spine of the maxilla resulting in an anterior septal dislocation. Septal fractures often are accompanied by injury to the nasal lining, such as lacerations of the septal mucosa or as hematomas of the septum. If injuries to the septum are untreated, deviations result which often need surgical intervention later.

## DIAGNOSIS

The diagnosis of fractures of the nasal bones should be determined by a careful history, clinical examination, and X-ray evaluation. The history can give us informative clews as to the

*Presented before the Section on Eye, Ear, Nose and Throat, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 18, 1955.*

mechanism of the trauma and its resultant deformity. As an example, a lateral blow with a blunt object can result in a simple fracture. If the force is great, a lateral deviation will be the consequence. Little difficulty is encountered in making the diagnosis, if the deformity is apparent. Careful palpation, provided the lesion is not obscured by gross swelling, will reveal the bones to be freely movable by the presence of crepitation. A meticulous intranasal examination, if necessary under general anesthesia, will determine any tears in the mucosal lining of the nose and any evidence of bleeding. When bleeding is present, there usually is a tear in the mucosa, and in any injury resulting in a tear in the lining mucosa, fracture generally is present. Hematomas of the septum may be further evidence of fracture of the nasal bones or an independent fracture of the septum.

X-rays should be a valuable aid in establishing the diagnosis, especially where swelling obscures the external contour and where the fragments are impacted. X-ray should be taken with a soft ray for both lateral and posterior-anterior projections to show the relationship of the bony arch to the soft tissues.

## TREATMENT

Early reduction of fractures of the nasal bones is a relatively simple procedure if undertaken soon after the injury and before the onset of marked swelling. This can be accomplished under local anesthesia for adult patients, and a short general anesthesia for children or highly sensitive individuals. Topical anesthesia consisting of 10% cocaine may be applied to the inside of the nose, anesthetizing the nasal ciliary nerve. External infiltration with 1-2% procaine blocking the external nasal nerve and the infraorbital nerve will give satisfactory anesthesia.

Most simple fractures can be set following anesthesia with a rubber covered Kelly forceps or some blunt instrument, to raise the fragments into position. This can be done in combination with external manipulation. Frequently a distinct click will be heard and felt by both patient and operator after fragments are replaced in their normal positions. Lateral displacements frequently will remain in position without any support but a splint is used for external protection and prevention of hematoma. The types of splints commonly used are stent compound, aluminum, or copper splints which are moulded to the contour of the nose and held in place with external taping. The splint remains from a week to 10 days, or longer if necessary.

To maintain the replaced fragments, protect the nasal mucosa, and control the bleeding to some extent, insert intranasal packing of a vaseline type into the nose. Packing generally can be removed within 24-48 hours, unless large tears of the mucosa are present or it is necessary to maintain the nasal septum in position. If there is a tendency for the deformity to recur, this may be due to marked comminution of the bony fragments, or incomplete replacement. The fragments may be realigned, if possible. Complicated fractures may need other methods of handling.

Fractures or displacements of the nasal septum, either occurring alone or with fractures of the nasal bones, should be given careful attention to insure proper replacement and restore an adequate airway. This can be done by grasping the nasal septum with an Asch forceps, rotating the displaced septum back into its midline position. If its position is not maintained, open reduction or submucous resection is performed, removing the fracture fragments and at the same time removing any hematoma present. This is followed by intranasal packing and external splinting, if accompained by a bony fracture. Hematomas of the septum without apparent fractures should be incised and evacuated. Antibiotics or other chemotherapy generally are given to guard against infection.

## INFANTS AND CHILDREN

In any suspected injury to the nose where there is a swelling one should not hesitate, under a light general anesthetic, to examine and gently elevate any possible depression with a blunt instrument high in the nostril. This is a simple procedure and at times its use may be questionable, but many deformities in adults which are difficult to account for by the patients may be a result of a neglected childhood fracture. Fractures with gross deformity present no difficult problem, and should be treated in much the same way as fractures in adults.

## SOFT TISSUE LACERATIONS

In compound fractures, care first must be given to the closing of any tears in the mucous membrane utilizing fine interrupted catgut su-

tures. The bones or cartilages can then be replaced in the usual manner, and a few interrupted sutures are inserted in the perichondrium or periostium to help secure their position. The skin is then closed in separate layers with fine black silk. Internal packing and external splinting, as described, are used for immobilization.

### LATE COMPLICATIONS

Late complications are external deformities of the nose associated with deviation of the nasal septum resulting not only in a gross disfigurement but also impairment of the respiratory function. Types of deformities may be variable and include twist or scoliotic nose, saddle or depressed nose, or dislocated septum. These deformities are the result of mismanagement or neglected injuries to the nose and patients usually have to resort to surgery for functional and cosmetic correction.

### SUMMARY

Early recognition, thorough clinical evaluation, and proper surgical management are imperative for restoring the nose to its normal contour and function.

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## The first impression

Bone marrow studies are done routinely in our medical institutions not only in suspect cases of malignancy but also in any case presenting a diagnostic problem. By the study of the normal we have learned to recognize early abnormalities, and malignant disease being one with such protean manifestations, we continually find first evidence of it in marrow imprints if this test is done frequently. *C. H. Jaimet, M.D. and H. E. Amy, B.A., R.T. Cancer Diagnosis by Bone Marrow Smears. Ann. Int. Med. April* 1956.

All parents of college students should investigate the health program of the college which their sons and daughters attend and insist on high standards there as well as in other divisions of the institution. Furthermore, they should be willing to pay for good service. Dana L. Farnsworth, M.D., Bulletin, NAT, May 1956.

## No age limit to cataract surgery

Cataract surgery can be done without endangering life or general well being in the extremely aged and even in the presence of chronic disease processes such as diabetes, arteriosclerosis, asthma, arthritis, and hypertensive cardiovascular disease (including borderline congestive failure). To illustrate the age group involved, and to demonstrate the safety of cataract surgery, I would like to cite my own experience. Of the last 300 consecutive cataract operations (excluding congenital and traumatic cataracts) that my partners and I have done, the ages of the patients have varied from 21 to 98 years. Half of the patients were over 66, 33 were over 80, and five were over 90 years of age. Using the safeguards to be described we have had no fatalities and have had few momentous complications. *Milton J. Lilly, Jr., M.D. Cataract Surgery in the Aged. West Virginia M.J. July* 1956.

# The Dermatologist's Role in Medicine

HANS M. BULEY, M.D., CHAMPAIGN

SINCE the introduction of antibiotics, the practice of dermatology—not unlike that of other clinical branches of medicine—has undergone drastic changes. The times when 30 to 50 per cent of dermatological practice consisted of syphilitics in various stages of the disease, and when pyodermas and other bacterial infections of the skin were major therapeutic problems, are gone forever. Scabies, formerly one of the most common diseases, has been virtually wiped out by modern insecticides. It may not be long until clinically applicable antibiotics with fungicidal effects are developed and when viral skin diseases can be overcome by immunological procedures.

Contrariwise, skin reactions to environmental conditions are much more common than in the past. Technological trends in industry, with increasing use of man-made complex synthetic materials, commonly found in every household and shop, have greatly augmented the incidence of allergic eruptions or contact irritations. The incidence of occupational dermatoses has been rising for the same reason. Furthermore, the marked increase in population, the increasing rate of life expectancy and, finally, the ever spreading skin consciousness of the public, especially with regard to cancer, have increased the public demand for dermatological care. What part, then, is the dermatologist expected to play in the light of these altered circumstances of modern life?

If dermatological activities are divided into three basic areas—namely, diagnosis, therapy, and research, the dermatologist's position can be surveyed more clearly. Diagnosis, in dermatology as in any other branch of clinical medicine, is the first and most fundamental approach. Dermatologists have been criticized and often ridiculed for their love of detailed descriptions and flowery terminology, which to the nondermatologist does not seem to bear any relationship to general pathology and medicine. Perhaps there was once a time when dermatological morphology was sported excessively and considered the crown of dermatological achievement. Let us be fair, however, and not forget that the skin, because of its complex anatomy and functions, is capable of producing a much greater variety of pathological pictures than any other organ in the body. Therefore, a careful inventory and classification of all morbid processes is necessary to create a sound basis for further study. The modern dermatologist has profited much by the painstaking diagnostic and descriptive work of his predecessors and is greatly indebted to them for their achievements. Diagnostic skill in the morphology of skin disorders still is the most important prerequisite and the most valuable asset of the modern dermatologist, without which he would be useless and expendable to his patients and colleagues.

Beyond recognizing the morphological changes in the skin, the dermatologist must endeavor to assess the cutaneous pathology in relation to the general medical picture. For instance, certain constitutional patterns, such as the xerotic and seborrheic habitus, have been found to produce fairly characteristic eruptions. Allergic and psychoneurogenous mechanisms are considered in terms of multiple pathogenetic background factors. Further, irregularities in the gastrointestinal tract, dietary behavior, carbohydrate metabolism, vascular response, hormonal functions, and other systems of general physiological interest are now associated with the study of abnormalities of the skin. It is evident, therefore, that dermatological thinking—even in the realm of pure dermatological diagnosis — has approached that of the general physician, and on this basis a much better mutual understanding between skin specialist and nondermatologist is about to develop.

In the field of therapy, as in diagnosis, there is a logical dualism, resulting from historical development of topical treatment, which seems to be the traditional prerogative of the dermato-

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*Chairman's address presented before Section on Dermatology, 115th Annual Meeting Illinois State Medical Society, Chicago, May 19, 1955.*

logical expert, and of general medical measures. Only by judicious application of both can rational and successful treatment be effected. Local treatment methods in the broadest sense, including radiation and physical therapy, are not just an accumulation of hit-or-miss procedures, as they are often understood to be by the nondermatologist. Rather, they represent the experience of a century of careful systematic pharmacological and therapeutic study. Proficiency in applying topical medication and securing its optimal effects does not depend upon instinct alone although no one will deny that intuition is an important factor in dermatology as in any other field of clinical medicine. It is the result of careful, patient, and methodical observation over a period of years.

There are many simple skin conditions which the general physician is well equipped to treat, particularly because of his familiarity with the patient's history and background. On the other hand, the know-how of topical therapeutic methods, not unlike carefully acquired surgical skill, is still important, and it is here that the expert can fill a gap and prove himself a true friend and helper to his nondermatological colleagues.

From what has been said about modern diagnostic approaches, it becomes apparent that the dermatologist cannot limit his therapeutic work to the realm of local procedures. Inevitably, he must concern himself with the broad medical aspects and he cannot be expected to secure lasting therapeutic effects unless he incorporates the general medical management of a case into his therapeutic regimen. In doing so, he must strive to keep abreast of progress in general medicine, he must be diligent in following the general medical literature, and he must be capable of using sound judgment in recognizing his own limitations.

Pure research is the soul of all medical science and in this field, dermatology has an outstanding record. In the early years of modern dermatology, the discovery of fungous organisms as the cause of certain skin diseases led to the great discoveries of the bacteriological era. Since then, dermatologists have taken leading parts in the development of the fields of pathology, histology, immunology, allergy, radiation biology, carcinogenesis, psychosomatic medicine, and industrial medicine. The present generation of dermatologists has widened the scope of dermatological investigation still further, and in the past 30 years the wealth of information available is overwhelming.

It is unfortunate that the nondermatological physician, with some exceptions, has little knowledge of these progressive activities. Dermatologists are called too conservative, too old-fashioned, and too static in their thinking. This lack of recognition may be due to poor public relations on the part of the dermatologists. But it is more likely due to the fact that the general physician never develops an intimate interest in the field of dermatology. He has no opportunity to gain adequate insight into dermatological problems when he should—namely, at the medical school and internship level. It is not that we are lacking capable teaching personnel, in which the medical schools of Illinois particularly excel. But, partly by necessity forced upon us by an overcrowded curriculum, partly by a lack of appreciation on the part of the university administrators, dermatological teaching and hospital facilities have been badly neglected in time, space, and funds. In view of the sheer number of skin problems the general practitioneer sees in his office, which has been estimated at 10 per cent of his total case load, the medical profession, as well as the public in general, has a right to ask for a re-evaluation of this problem.

In appraising the present position of dermatology in medicine, I believe—in spite of the many changes which have taken place in recent years—that dermatology still occupies and successfully maintains the province to which it is historically entitled. Much has been accomplished in the past but more remains to be done by dermatologists of the future. The results of their work will continue to widen the horizons of medicine and will continue to help the sick, a task to which all physicians are pledged.

# Problems of Cataract Surgery With a Round Pupil

Edward C. Albers, M.D., F.A.C.S., Champaign

BECAUSE of the popularization of wound suturing in the late 30's and early 40's, cataract surgery has gone through a great change within the last 20 years. Today's surgeon seldom does a cataract operation without using a suture of some kind. In addition marked changes in postoperative care are noted. The patient is not tortured by being kept in a dark room, flat in bed, with sand bags on each side of his head. Serious postoperative psychosis in the older patient, which was so common two decades ago, is rare today.

With the introduction of wound suturing, new systems of cataract surgery have been developed along with preservation of the iris sphincter. In the presuture days, attempts to preserve the iris intact was a hazardous procedure and led to many cases of iris prolapse with all its associated complications. Many surgeons, however—even with the increase in safety measures and newer techniques—feel that iridectomy should be done in all cases. They, therefore, always remove a piece of the iris. Others use the round pupil technique in only a few selected cases, while a number, especially the younger group, do iridectomy only occasionally. Those who grasp the lens capsule at the upper pole often will do iridectomy, while those who tumble the lens during extraction find it less difficult to preserve the iris sphincter. There are many arguments pro and con for the different techniques for lens delivery. The occasional operator almost always prefers iridectomy, because he feels it is a safer procedure and has less complications.

The surgeon who plans cataract surgery on a one-eyed patient is likely to approach the operation with much more thought and preparation than he would give to a patient with two eyes. He uses the system which is safest in his hands. I felt that by getting the views of various surgeons in this type of case, I would be able to determine the general feeling of ophthalmologists as a whole toward round pupil surgery, because the surgeon chooses the method which gave him the highest percentage of success with all cataract operations. I recently communicated with 12 members of the Central Illinois Society of Ophthalmology and Otolaryngology who do considerable cataract surgery and asked them the following question: "If you had a patient with only one eye and the patient had an uncomplicated cataract, would you do iridectomy or would you extract the lens through an intact round pupil?"

Eight members preferred iridectomy because it was their usual procedure and it gave them the highest percentage of success. Four members preferred the round pupil since they felt that it was no more hazardous than extraction with iridectomy.

I also find that in such a case Chandler would select his regular procedure which seems safest; Verhoeff would select the operation which would be the safest; and Schliveh prefers iridectomy and extracapsular extraction. Post prefers iridectomy.[1] Gailey[2] does iridectomy in patients who do heavy labor, and if the lens is mature he does an extracapsular extraction. He also does iridectomy where the iris sphincter is rigid or where the iris persists in prolapsing during the operation. He states that if a surgeon feels that a round pupil is good enough for a two-eyed patient, it should be good enough for a one-eyed patient.

My own opinion is that the round pupil extraction is no more hazardous than other techniques, especially when the pressure traction method is used, the lens tumbled, and the lens is grasped as far down near the inferior pole as possible. I usually limit iridectomies to cases where

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*Presented before Section on Eye, Ear, Nose & Throat, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 18, 1955.*

the pupil is rigid and will not dilate, where there is considerable iris atrophy, or where glaucoma is present.

I try to preserve the iris sphincter because I believe there are the following advantages to a round pupil:

1. Iris above serves as a plane of reference.
2. Maneuvers do not injure the vitreous and the iris acts as a barrier during extraction.
3. It is easier to clear the zonula from the wound.
4. There is less likelihood of injuring the hyaloid at the time of surgery.
5. I have always felt that a good iris sphincter helped keep the vitreous out of the anterior chamber. Since vitreous prolapse into the anterior chamber is quite common, I am not so sure about this.
6. There is less photophobia.
7. There is better protection from radiation beyond the visible spectrum and the inner eye is better protected from excessive light.
8. It aids visual discrimination because of the diaphragm.
9. Visual acuity is better.
10. There is less distortion of the image.
11. Patients are much easier to refract and especially to retinoscope.
12. Cosmetic appearance is much better. Some do not like the appearance of an eye with an iris colomboma.
13. The appearance of an eye with a round pupil gives more satisfaction to the surgeon.

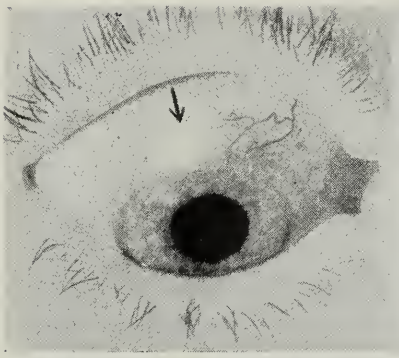
Some of the advantages of iridectomy are as follows:

1. It is easier to grasp the lens capsule at the upper pole.
2. The lens is more easily delivered when the sliding method is used.
3. Some feel that retinal detachment is less frequent in aphakia.
4. Iris prolapse is less frequent.
5. Vitreous block does not occur.

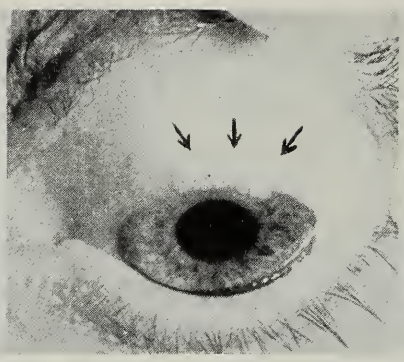
Our average cataract patient has a general checkup before surgery. The night he goes to the hospital he has a blood count and urinalysis, and Aureomycin ointment® is used in both eyes. Before retiring, he is given 1½ gr. Nembutal® and an enema. We usually perform our cataract surgery in the morning because the patient is in a more relaxed state and the surgeon has less tremor after a night's sleep. Two hours before surgery 5% Homatropine drops are instilled into the eye. One and one-half hours before surgery the patient is given 1.0 gm. chloral hydrate and 0.050 gm. of Thorazine® by mouth. One hour before surgery the patient is given 0.075 gm. Demerol® by hypo and 2 mm. of 10% Neo-Synephrine® are instilled into the eye. This preoperative medication leaves the patient in a good mental state for surgery. The pupil usually is well dilated. In the operating room, Pontocaine® is instilled into the eye several times before surgery. An O'Brien akinesia is done and 4% Novocaine® with added adrenalin is injected retrobulbarly. Novocaine also is injected into the upper lid near the margin to facilitate handling it.

Before surgery is begun, the lashes and brow are cut, the skin is cleansed with soap and water and painted with untinted tincture of Metaphen®. The conjunctival sac is thoroughly irrigated with 1-5000 merthiolate solution and saline solution. A Guyton-Parks speculum and a superior rectus bridge suture are inserted to control the position of the eyeball. A large conjunctival flap 6 mm. wide is turned down from 9 o'clock to 3 o'clock. Three pre-placed McLean-type corneoscleral 6-0 silk sutures are inserted at 10, 12 and 2 o'clock. The incision is made with a keratome and scissors. This method of making the incision is preferred to the Graefe knife because the average ophthalmologist with the average skill can make an excellent incision every time. No matter how dexterous a surgeon may be, I am sure he cannot make a good incision every time with a Graefe knife. Also, pre-placed sutures make the knife incision more difficult and my feeling is that pre-placed McLean sutures can be much more accurately placed and give a much nicer wound closure than any other method of suturing.

Since the pupil usually is widely dilated, the iris must be grasped and pulled downward and two peripheral iridotomies are done at 10 and 2 o'clock. The capsule is then grasped with a Bell-type erisophake with a cup with a wide flange. The first maneuver is to raise the erisophake slightly and put counterpressure at one point at the limbus at 6 o'clock. In most cases,



**Case 1. Figure 1. H. H. Cotton under the conjunctival flap.**



**Case 2. Figure 2. G. J. L. Fistulizing wound.**



**Case 3. Figure 3. M. L. Injury to the iris while making the incision.**

ruptures of the zonula are easily started in this area. The lens is delivered by tumbling. The iris is then replaced with the minimum of manipulation. The sutures are tied and saline or air is injected into the anterior chamber. The conjunctival flap is then re-sutured into place with a running 4-0 plain catgut suture. Pilocarpine drops® and Eserine ointment® are instilled. Both eyes are bandaged for 24 hours. The unoperated eye is uncovered and the patient is ambulatory after the first day. All dressings are removed after the fifth postoperative day. The patient is released from the hospital on the 10th day and the sutures are removed on the 16th day.

Complications and their solutions are illustrated in the following case reports:

Case 1. Figure 1. H. H. Cotton under the conjunctival flap. This lady had an uneventful cataract extraction through a round pupil. A 6 mm. conjunctival flap was dissected down to the limbus and three preplaced corneoscleral sutures were inserted. The incision was made with the keratome and scissors. After the lens was delivered, the iris was replaced and the sutures were securely tied. A running plain catgut suture securely anchored the conjunctiva in place. Recovery was uneventful except for some edema of the conjunctival flap at 12 o'clock. Careful study with the biomicroscope revealed a large piece of cotton under the conjunctival flap. It had been our custom to use cotton dental rolls for sponges. Apparently a piece of cotton become detached and remained unnoticed under the conjunctiva. In order to avoid this accident, we now use fine-grain cellulose sponges instead of cotton. We also have replaced cotton sponges with gauze on our eye trays.

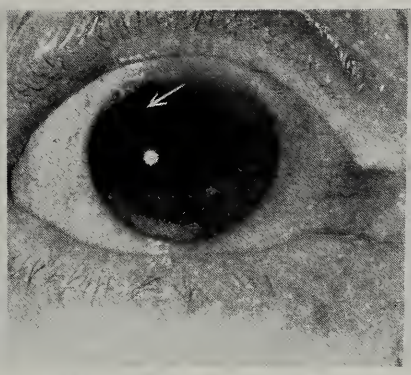
Case 2. Figure 2. G.J.L. Fistulizing wound. In this case only two pre-placed corneoscleral sutures at 11 and 1 o'clock were used. The incision was made with a keratome and scissors, and the lens was easily delivered within its capsule. Two iridotomies were done. There was some difficulty in replacing the iris before the sutures were tied. The conjunctiva was closed by a running silk suture. There was considerable edema of the conjunctival flap following surgery and on the 16th day when the sutures were removed fistulization of the wound was noted. This complication was caused by inadequate and improperly placed sutures. The temporal suture was too deeply placed and probably entered the anterior chamber. This error can be avoided by not placing the sutures too deep. It also is important to get the wound free from iris, iris pigment, zonular fibres, and conjunctiva. The conjunctiva is best kept out of the wound by carefully sewing it in place with a running catgut suture.

Case 3. Figure 3. M.L. Injury to the iris while making the incision. This 70 year old white male had a shallow chamber previous to surgery. Examination of the lens revealed moderate sclerosis of the cortex and marked sclerosis of the nucleus. A conjunctival flap was made and three pre-placed sutures were inserted. There was some difficulty making the incision with the keratome. When the incision was being enlarged, the iris sphincter was accidentally cut. No iridotomies were done. The lens was delivered easily and convalescence was uneventful. The final vision was 20/15. Accidental injury to the iris is an avoidable complication. It is less likely to happen if specially designed right and left scissors are used. It is better to use a scissors of the Aebli type with dull tips and the proper angle of the blade. The tip of the blade should always be visible when the scissors are introduced into the wound; the assistant can push the conjunctival flap out of the way while the scissors blade is inserted. The blade must be kept parallel with the plane of the iris. Sometimes in shallow chambers short snips rather than one long cut will prevent this accident.

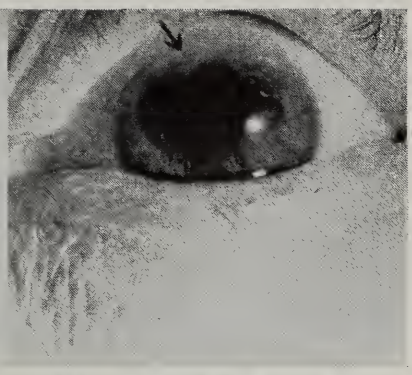
Case 4. Figure 4. M.H. Opening of the wound during the removal of sutures. This patient had an uneventful cataract extraction through an intact pupil. On the 10th day the pupil was round, the iris was in good position, and there were no root adhesions. Both iridotomies were open. The patient returned to the office on the 17th day for removal of the sutures. The eye was carefully anesthetized with Pontocaine® and a Weeks speculum was inserted to hold the lids open. The patient was highly nervous, and when my associ-



Case 4. Figure 4. M. H. Opening of the wound during the removal of sutures.



Case 5. Figure 5. H. D. Injury to the corneal endothelium. Adhesions between the hyaloid membrane and Descemet's membrane.



Case 6. Figure 6. R. A. Prolapse of the iris.

ate attempted to hold the suture preliminary to cutting it, the patient moved, rolled his eye upward, the wound opened slightly, and an iris prolapse occurred. In highly nervous individuals who have little control of their reflexes, it is far better to wait three or four weeks before attempting to remove the sutures. It is wise to do an O'Brien akinesia in addition to using topical Pontocaine. In one case I also did a retrobulbar injection. The suture never should be grasped with a forceps before cutting it. If this maneuver is necessary, it is better to use a forceps with smooth jaws and weak blades because the average ophthalmologist does not have reflexes quick enough to loosen his grip if the patient moves. A strong-bladed scissors with sharp points, especially made for cutting corneoscleral sutures, should be used. Catgut sutures may be used but they are hard to handle; we prefer sharp Grieshaber needles and 6-0 silk.

Case 5. Figure 5. H.D. Injury to the corneal endothelium. Adhesions between the hyaloid membrane and Descemet's membrane. This patient had a shallow anterior chamber due to intumescent cataract. Tension was moderately elevated. Quite a bit of bleeding into the anterior chamber occurred when the iridotomies were done, which necessitated much irrigation of the anterior chamber. After the lens was delivered, we had considerable difficulty replacing the iris and the iris diaphragm was almost against the lens. The chamber formed in 24 hours but the hyaloid was in contact with the cornea in the upper temporal quadrant. An opaque area developed and edema extended down over the apex of the cornea. This gradually receded in about one year, but the opaque area remains and there is some edema of the stroma and epithelium in that area. The vision is 20/40. The corneal endothelium usually is injured by the irrigator needle, erisophake, or capsule forceps, specially when the chamber is shallow. We believe we are less likely to injure the endothelium if a Randolph cyclodialysis cannula is used as the irrigator when blood is washed out of the anterior chamber. When the erisophake or forceps is introduced into the anterior chamber, it is better to separate the lips of the wound well by lifting up on the conjunctival flap. There is then little danger of injury to the endothelium of the cornea. When there is any possibility of the vitreous touching the cornea or when the endothelium of the cornea is diseased, it is well to inject a large bubble of air into the anterior chamber after the sutures are securely tied.

Case 6. Figure 6. R.A. Prolapse of the iris. This 80 year old white male was operated by me by my regular technique. The lens was easily expressed. The eye was very soft during surgery, so that the iris diaphragm collapsed, making it easy to replace it. After I had tied the sutures, it was noted that the temporal suture was a little loose. Since the conjunctiva was securely sewed down by a running suture, the corneoscleral suture was not replaced. Eight hours after surgery, this patient suddenly developed severe pain in his eye and the iris prolapsed. It was noted that it prolapsed between the temporal suture and 9 o'clock and was well covered with conjunctiva. On the tenth postoperative day it was excised. The final vision was 20/20. Iris prolapse can be avoided by securely suturing the wound and carefully replacing the iris after the lens is delivered. Restlessness and discomfort in the patient increases the chances of this hazard. Postoperative nausea can be controlled easily with Thorazine and good nursing.

Case 7. M.R. Chandler's Syndrome following cataract extraction. This 80 year old white female had an easy cataract extraction through a round pupil. Only one iridotomy was done at 12 o'clock. It was noted that the chamber was formed 24 hours after surgery and the pupil was small and round. After the sixth day, the chamber became more shallow and the eye became uncomfortable. Vitreous could be seen in the iridotomy opening but did not prolapse through the pupil. Three weeks later the chamber was very shallow. The chamber angle could not be seen with the gonioscopic prism and the tension was 52. The patient was reoperated. An incision was made through the sclera 3 mm. from the limbus. The ciliary body was separated from the sclera and a peripheral iridotomy was done. The chamber deepened at once. The highest tension

recorded since surgery was 18 (Schiotz). The vision was 20/40. Chandler's Syndrome, or vitreous block, is most commonly seen following round pupil surgery. Even when peripheral iridotomies seem open, it may occur. It occurs rarely and can be avoided by minimal manipulation of the iris during surgery and two or three large iridotomies to get good communication between the posterior and anterior chambers. It occurred three times in 500 consecutive round pupil extractions. A large peripheral iridotomy usually solves the problem.

Case 8. M.L. Vitreous prolapse into the anterior chamber. This patient had a successful cataract extraction through an intact iris sphincter. There were two large iridotomies at 10 and 2 o'clock. One month after surgery the vitreous formed a slight convex dome in the pupillary area. It gradually prolapsed until at the end of a year it completely filled the anterior chamber. The cornea remained clear and the vision remained 20/20. Tension was always normal. Two years later the hyaloid membrane had ruptured and the vitreous fibers were initimately mixed with the aqueous. No reduction of vision has occurred. It is thought the vitreous either swells by taking up more fluid or becomes detached posteriorly and thus herniates. The cause of vitreous herniation is unknown. It is more commonly seen where the iris sphincter is preserved.

Extraction of a cataract through an intact iris sphincter is not a common procedure among American ophthalmologists. In our experience, however, the system of round pupil cataract surgery described by me is no more difficult and involves no more complications than any other system of surgery. Even in a small community such as ours where we must rely occasionally on inexperienced assistants and on a rapidly changing operating room staff which must be responsible for every kind of surgery, our technique can be performed easily. I have operated with student nurses, office nurses, and alone and have gotten along well if strict adherence to detail is practiced.

Practically all the complications mentioned in this paper can be avoided. None has caused serious loss of vision. A number of other complications are not mentioned in this article such as secondary uveitis due to excessive instrumentation, loss of vitreous, peripheral synechia, and occlusion of the pupil by secondary membrane due to improper use of Atropine®. These, too, may be avoided by proper adherence to detail.

Since the advantages of round pupil surgery far outweigh the disadvantages and since the complications are not numerous and practically all avoidable, this system of surgery is our method of choice.

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## The outcome of acute renal failure

Renal function was studied in 16 patients who had recovered from acute renal failure. Within six months, the phenolsulfonphthalein excretion and specific gravity were normal. However, clearance values remained below the lower limits of normal in most patients. These findings are consistent with permanent damage of mild degree. After recovery from acute renal failure, progressive diminution of renal function does not occur unless some other disease causes additional renal damage. *John T. Finkenstaedt, M.D. and John P. Merrill, M.D. Renal Function after Recovery from Acute Renal Failure. New England J. Med. May* 31, 1956.

# Rupture of the Uterus

**Charles D. Krause, M.D. and George P. Vlasis, M.D., Chicago**

THOUGH rupture of the uterus is not a common accident in obstetrics, the mere mention of it causes panic in many a delivery room. This emergency, probably more so than any other, overtaxes the diagnostic and surgical abilities of the physician. It is generally agreed that the term "ruptured uterus" applies to rupture of a gravid uterus with a viable fetus and thus excludes ectopic pregnancies, ruptured interstitial cornual pregnancies, and those following curettage. In the majority of instances this entity is "man-made" in the sense that it most often ensues following previous cesarean sections and major operative procedures on the uterus. Spontaneous rupture of the intact uterus before the onset of labor is exceptionally rare.

Large statistical surveys reveal a high maternal and fetal mortality. Fitzgerald, Webster, and Fields[1] in a review of 92,226 deliveries at Cook County Hospital, wherein 42 ruptured uteri were incurred, found the maternal and fetal mortality 54.76 and 79 percent respectively. They further noted that the rate of multipara to primipara was approximately 9:1, as is noted generally elsewhere. Any entity that carries such a tremendous loss of mothers and infants is of major concern to all of us.

Our purpose here is to present some of the silent and more unusual types of rupture that were incurred in both a service and private practice and to outline procedures in diagnosing ruptured uteri. Lack of recognition as evidenced in this group, may well cause maternal and fetal death.[2]

Commonly, uterine rupture, excluding previous cesarean section scars, follows internal version and extraction, neglected obstructive labor, forceps delivery through an undilated cervix, forceps, delivery through an undilated cervix, and unrecognized pathological constriction rings), manual removal of the placenta, and injudicious use of pituitary extract.

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Some of these factors are being deleted and the day is near at hand when internal version and extraction will be reserved for delivery of a second twin and rarely for other indications. This should be so, since — exclusive of ruptures following previous cesarean sections — internal version and extraction is one of the leading major operative procedures resulting in rupture of the uterus. The clinical picture presented may vary from the classical one of the patient who cries out and grips here abdomen at the time of rupture, to one in which the patient presents only a few minimal but important signs.

In 11,257 deliveries at the University of Illinois Research and Educational Hospital, obstetrical services from 1944-1954, seven ruptured uteri were incurred. Of these, five occurred in previous classical cesarean section scars and one in a previous low cervical cesarean section. The remaining case is presented here.

Case 1. A Negro woman, 37 years of age, gravida VIII, para VII, entered the hospital with desultory pains and was noted not to be in active labor. Following a medical induction she had a NSD from a ROA position. First stage, 1 hour 30 minutes; second stage, 16 minutes; third stage, 4 minutes. Postpartum bleeding 2,000 cc. due to uterine atony was noted. A uterine packing was inserted and oxytocics were administered. Bleeding continued after uterine packing. Ergotrate 1 cc. and Pitocin® IV, 500 cc. plasma, 2,000 cc. of blood, and nasal 02 was given. The uterine packing was removed and the uterus was repacked. Bleeding continued through the second pack and the patient went into deep shock. An additional 1,500 cc blood was given and a laparotomy done. A right broad ligament hematoma was noted and a supracervical hysterectomy was performed, there being noted a tear in the lateral wall of the uterus in the region of the right uterine artery. After abdominal closure the patient continued to bleed vaginally and was in shock. Blood transfusions continued and a vaginal pack was inserted but this failed to control bleeding. A second laparotomy revealed bright red bleeding from the right broad ligament and the right internal iliac artery was ligated. After closure of the abdomen, bleeding continued vaginally. It was decided to remove the cervix vaginally and thus control the bleeding. This was done and the patient rapidly improved thereafter. She developed

thrombophlebitis postoperatively but was discharged on her 15th postoperative day as improved.

At the Evangelical Hospital, Chicago, in 22,426 deliveries from 1945-1955, nine ruptured uteri were recorded. Of these one followed a NSD; one a low cervical cesarean; one a classical cesarean; one version and extraction; one, low forceps delivery; and the remaining cases are presented here:

Case 2. Mrs. A.B., para II, gravida III, entered hospital with irregular contractions at 12:35 a.m. Labor became established at 3:30 a.m. and at 5:15 a.m. she was thought to be 6 cm. dilated and at a (-3) station. Suddenly no fetal heart tones were audible. Upon rectal examination approximately 100 cc. of blood was noted to escape from the vagina. The attending physician was unable to determine the status of the cervix. BP 120/70, pulse 60 to 80. She had slight backache, the head was noted to be floating and to be in an oblique presentation. Vaginal examination by the consultant three hours later revealed cervix 2 cm. dilated and "tissue" felt between the fetal head and examining finger. Impression was that this was a central placenta previa, and in spite of a dead fetus, laparotomy was ordered. At laparotomy an 8 pound 12 oz. infant, together with the placenta, was found lying in the abdomen with the head in the cul-de-sac and against the right lateral wall of the pelvis. Approximately 300 cc. of free blood was in the abdomen and there was a large rent in the left lateral wall of the lower segment and broad ligament. Supracervical hysterectomy and left salpingo-oophorectomy was performed, 500 cc. blood was given, and patient made an uneventful recovery. All previous pregnancies in this patient had terminated uneventfully and she had never had any surgery.

Case 3. Mrs. L.F. gravida IV, para II, known diabetic, after a prolonged first stage of 24 hours and second stage of 26 minutes was delivered of a 12 pound 13½ oz. infant by midforceps rotation from an LOT position and (No. 1) station. Shoulder dystocia was encountered and after considerable difficulty with forceful fundal pressure, the infant was delivered. Immediately following this, excessive bright red bleeding was noted. The uterus was explored and a fundal rupture was noted. Immediate laparotomy was performed. There were noted to be two separate and distinct lacerations in the body of the uterus, measuring 5 and 3 cms. in length on the anterior surface of the uterus. A supracervical hysterectomy was performed and her postoperative course was uneventful. Blood replacement was begun in the delivery room.

Case 4. Mrs. M.M. gravida IV, para III, entered the hospital with desultory pains. Diagnosis of primary uterine insertion was made by consultant and repeat SS enema ordered. Following a labor of 21 hours, an 8 pound 1 oz. infant in ROA position was delivered by low forceps. Third stage, three minutes. Ergotole® 1 cc. and Pitocin 1 cc. 1M given (routine). Patient began bleeding heavily. Uterus was packed 17 minutes later by consultant. IV Pitocin and blood begun. Twenty-five minutes later, bleeding through pack, pulse 130 and weak. Second consultant removed pack, uterus explored and a rent noted right lateral wall of lower segment extending into the broad ligament. Immediate laparotomy revealed hematoma into right broad ligament and the uterine rupture. A supracervical hysterectomy was performed; 2500 cc. of whole blood were given. Postpartum course was uneventful.

Case 5. Mrs. T., 39-year old primipara, 34 week gestation, entered hospital with ruptured membranes and irregular contractions. Four days later patient went into active labor, pains of poor quality, and dysfunctional in character. After 30 hours of labor, the head came down on the perineum and a living infant was delivered by low forceps in LOP position under saddle block anesthesia. Placenta retained one hour and 30 minutes. Placenta was manually removed with difficulty. Fifteen minutes later patient began to bleed moderately and went into shock. Plasma and blood begun. One-half hour later, pulse 160, uterus was explored and ruptured uterus was diagnosed. No Bp and no pulse obtainable. Respirations, 10 per minute. Consultant advised immediate laparotomy. No anesthesia, only intranasal 02 was given. Patient had received 9 units of blood, 1 plasma, and 4 dextran. Abdomen was opened and approximately 3000 cc. of blood was noted in the abdomen. Complete rupture of left lateral wall of lower segment was noted. A total abdominal hysterectomy was performed and the heart stopped just as the uterus was being removed and vessels were being ligated. Massage of heart through diaphragm was begun to no avail. Abdomen was closed postmortem.

In these 16 reported ruptured uteri, there was one maternal death and five fetal deaths.

## DISCUSSION

Several of these cases presented some classical signs or symptoms of uterine rupture. Some were noted to have normal spontaneous deliveries and the first evidence of rupture was not discovered until the third stage of labor or some time thereafter. It is imperative that the uterus be explored following any major operative obstetrical procedure, manual removal of the placenta, postpartum hemorrhage not controlled with oxytocics, and following vaginal delivery of a patient who has had a previous cesarean section. It might even be wise to explore the uterus of any woman after any type of delivery. Exploration of the uterus should be performed systematically and not in a haphazard fashion of just thrusting one's hand into the uterus and feeling for a large rent.

Many ruptures are incomplete ruptures and will be missed unless the uterus is examined methodically. When one is to explore the genital tract because of postpartum hemorrhage or shock, the clitoris, vagina, and cervix are explored and examined for lacerations, under strict

sterile precautions with redraping of the patient and re-gloving with gauntlet gloves. The hand is inserted into the uterus, after the uterus has been relaxed with adequate anesthesia. The fingers sweep both vertically and horizontally across the entire corpus covering both anterior and posterior surfaces, including the fundus. In this fashion one can detect a vertical, horizontal, or oblique laceration. The same procedure is followed in exploring the lower uterine segment. This examination is performed bi-manually and is extremely important especially in exploring uteri that have previous cesarean section scars. If the uterine scar is noted to be abnormally thin, then in her subsequent pregnancy the patient should have a repeat cesarean section.

In performing a manual removal of the placenta, the uterus should be routinely explored afterward. This can be accomplished without having to reinsert the hand through the entire genital tract to reach the fundus. In removing the placenta the hand is inserted into the lower segment and seeks the margin of the placenta. The placenta is separated from the uterus in a horse-shoe like sweep with the back of the hand. The top of the placenta is reached and the topmost portion lies within the operator's hand. It is brought into the lower uterine segment and then either the assistant or operator places traction on the cord thus delivering the placenta. There is only one other instance in which traction on the cord for delivery of placenta is permisible and that is at time of cesarean section. Traction is not placed until the placenta is completely separated and delivered into the lower segment. With the placenta delivered by traction, the hand remains in the uterus and exploration of the entire uterus is performed. Following removal of the hand from the genital tract, the cervix, vagina, and clitoris should be examined for lacerations. With the use of IV oxytocics, the use of uterine packing is reserved for the rare and exceptional case and then it is used only once.

Repacking is mentioned only to be condemned. Whether a patient should be delivered vaginally following previous cesarean section remains an individual problem. It depends upon facilities for watching such a patient at all times, availability of blood banks, her previous postoperative course, the type of cesarean section, and the original indication for section. The question whether a repeat cesarean section should always be done is not within the scope of this presentation. With early recognition of dystocia, the discriminating use of IV Pitocin with all criteria for its use being fully met, recognition of constriction rings, and constant vigilance for detection of a ruptured uterus, we can all help in reducing this preventable maternal and infant mortality rate. One must not hestitate to explore a uterus if bleeding persists in spite of intravenous oxytocics (drip method).

The uterus should be routinely explored followed major operative procedures and manual removal of placenta. By thus "educating one's hand" while performing a definite service to his patient, he will most certainly detect these incipient and treacherous atypical ruptured uteri.

## SUMMARY

1. Attention is drawn to several atypical uterine ruptures that occurred in labor and presented unusual features with a review of five case histories.

2. Discussion of routine exploration of uterus where indicated and a suggestion for a method of exploration is made.

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# Acute Fractures of the Carpal Navicular Bone

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FRACTURES and dislocations involving the carpal bones represented 1.5% of all bone and joint injuries on Ward 34 Fracture Service of Cook County Hospital in 1,000 consecutive admissions. Fracture of the navicular bone was by far the most common carpal injury.

To those of us who expect to treat carpal injuries, a thorough knowledge of the anatomy of the carpal bones is essential. Otherwise, indistinct fractures and minor subluxations will be frequently passed over.

The carpus bones are divided into a proximal row and a distal row. The proximal row consists of the navicular, lunate, triangular, and the pisiform bone. These are largely cartilaginous on their surfaces. Ligaments attach on their remaining portions. In contrast, the distal carpal row, which consists of the greater multangular, lesser multangular, capitate, and the hlamate bones, is less cartilaginous but has more extensive ligamentous attachments.

Of these, the navicular and lunate bones are more exposed to trauma because of their location and their movable articulation with the radius. The carpal navicular bone, with which we are concerned here, articulates with the radius, the greater multangular, the lesser multangular, the capitate, and the lunate bones.

In 1938, Ogletz and Halbstein, in examining 297 injected specimens, described their findings on the blood supply to the carpal navicular bone. In two-thirds of the cases, the vessels are distributed equally throughout the length of the ligamentous ridge. In 13% of the cases, no vessels directly enter the proximal half; and in 20%, there is a scanty vascular supply to the proximal half.

When any bone is fractured, the blood supply to the fragments may be interrupted temporarily. This is particularly true of the carpal bones, especially the carpal navicular bone in those cases in which no vessels enter the proximal half. If the fracture line is proximal to that area, then nutrition to the proximal fragment may be interrupted. Such interference with the blood supply to the proximal fragment explains the aseptic necrosis of this fragment in a large percentage of fractures of the carpal navicular bone in the middle and proximal regions. With immediate reduction and plaster cast immobilization, the blood vessels usually are restored across the fracture line and revascularization of the proximal fragment takes place. With delayed treatment, a scar may form at the fracture site and the blood channels may be sealed off.

For studying the carpal navicular bone, it often is convenient to photograph both hands on the same plate. In a suspected fracture of the carpal navicular bone, three routine views should be taken: The P.A., the lateral, and the oblique. The P.A. view should be taken with hand in extreme ulnar deviation. The oblique view should be taken to bring the carpal navicular bone into full profile.

At times, a recent fracture may be so impacted or so slight that the fracture line is not evident on initial examination even with repeat films. In these cases, if a fracture of the carpal navicular bone is suspected — and this point cannot be stressed too strongly — the wrist should be properly immobilized in a plaster cast and repeat films taken in three weeks, at which time absorption at the fracture line may be visible. This is excellent treatment for a sprain and if a fracture of the carpal navicular bone is present, valuable time has not been lost.

Characteristically, fractures of the carpal navicular bone occur in the young adult male. According to Burnett, 94% of fractures of the carpal navicular bone occur in males and 60% occur in the below 30 age group.

Usually, acute dorsiflexion and sharp radial

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*Read before the Joint Meeting of the Chicago Chapter of the American College of Surgeons and the Chicago Orthopaedic Society on September 22, 1955.*

deviation of the wrist produces the injury. The force is applied indirectly to the carpal navicular bone through the index and middle metacarpal bones. Occasionally, it may occur directly to the tubercle of the carpal navicular bone as happens with a fall on the outstretched hand in ulnar deviation.

The symptom of fracture of the carpal navicular bone is pain in the radial aspect of the wrist. The physical signs are moderate swelling over the radial side of the wrist and tenderness over the "snuffbox" area. The hand grip frequently is weakened and with the hand radially deviated, percussion of the index metacarpal elicits pain over the "snuffbox" area.

Fractures of the carpal navicular bone occur in three main locations: 75% at the wrist or central part, 15% at the junction of the proximal and middle third, and 10% at the tubercle.

All fresh fractures of the carpal navicular bone should be immobilized at once in a circular plaster cast extending from the upper third of the forearm to the distal phalanx of the thumb and to the distal palmar crease of the hand. Usually, because of pain and swelling, only minimal dorsiflexion of the wrist may be obtained at the initial casting. But at 10 days or two weeks, the wrist can be immobilized in a circular plaster cast in a position of 30 degrees of dorsiflexion and 15 degrees of radial deviation. The fracture should be immobilized until X-rays reveal trabeculae across the fracture site. Rarely is this achieved in less than eight weeks. If necessary, immobilization should be maintained for four to six months and even longer.

In cases of a fracture in the very proximal portion of the carpal navicular bone, it often is better to excise the fragment than to immobilize and wait for healing.

Fractures of the tubercle of the carpal navicular bone almost always heal. This type of fracture is largely extra-articular and the blood supply to both fragments is maintained.

The comminuted fracture of the carpal navicular bone might be treated by primary excision of the entire bone. But unless there is great displacement it probably is better to immobilize the fracture the required time and do the excision later if symptoms justify it. The comminuted and displaced fragments may create abnormal friction with the surrounding carpal bones and the radius and lead to traumatic arthritis.

To accentuate the need for early diagnosis and proper immobilization, let us consider the case of a 22 year old male laborer who fell on his outstretched right hand on January 1, 1955. He had immediate wrist pain and visited a physician that afternoon. Mild swelling over the dorsum of the wrist, tenderness over the "snuffbox" area, and a positive percussion test pointed to the diagnosis of a fracture of the carpal navicular bone. This was confirmed by X-rays. The wrist was improperly immobilized in a neutral position with 5 degrees of ulnar deviation for six weeks. Proper immobilization was instituted with the wrist in 30 degrees of dorsiflexion and 15 degrees of radial deviation. Six months from the original injury, the fracture was not healed. X-rays at eight months were suggestive of trabeculae across the fracture site but healing was not complete. Early proper immobilization might have resulted in early healing for this young man.

A second case is that of a 43 year old laborer who fell on his outstretched hand, had pain in his wrist, and was told that he had a wrist sprain. Three months later, a second fall resulted in sharp wrist pain and he again visited a physician. X-rays revealed an old fracture of the proximal pole of the carpal navicular bone with nonunion at the fracture site and cystic changes of the proximal and distal fragments. The wrist was acutely painful and had limited motion. Had the original fracture been diagnosed, proper immobilization might have prevented this cystic degeneration and nonunion. Packing of a large cyst of this nature with cancellous bone has been advocated. However, it is our feeling that excision of the entire carpal navicular bone is preferable.

This again emphasized the need for early diagnosis and proper immobilization of fractures of the carpal navicular bone.

## SUMMARY

We have reviewed the anatomy of the carpal navicular bone and have discussed the mechanism of injury to this bone.

We have seen how early diagnosis can be made from the history, the physical findings, and proper X-ray evaluation.

Preferred treatment consists in maintaining

the wrist immobilized in a circular plaster cast in a position of 30 degrees of dorsiflexion and 15 degrees of radial deviation until the fracture is healed.

Finally, two cases were shown in which the failure either to correctly diagnose fracture of the carpal navicular bone or to properly immobilize fracture of a carpal navicular bone resulted in prolonged and unnecessary morbidity.

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## Public welfare

From the vantage point of today, the Commission also believes "the entry of the national government into the field of public welfare on a massive scale was clearly justified and very necessary. The stresses of the depression created burdens far beyond the fiscal capacity of the state and local governments. The social insurance programs initiated at the time are only now beginning to exert a significant ameliorating impact upon public assistance rolls." *Federal-State Relationships as Viewed by the Kestnbaum Commission. Pub. Aid in Ill. June* 1956.

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Although the new drugs are a most helpful addition to our armamentarium, they are not a substitute for the tedious but progressively successful tuberculosis control program developed painstakingly over the last half century which will lead eventually to our goal of eliminating all tuberculous infections, in other words, to the goal of no reactors to the tuberculin test. James E. Perkins, M.D., Managing Director, NTA, J. Lancet, April, 1956.

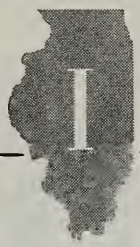
## Radioiodine

At present, most doctors experienced in the field of medicine consider radioiodine the preferred treatment for thyrotoxicosis in patients above age 40 without goiter, or with diffuse goiter of a certain estimated weight, and patients of any age with persistent or recurrent postoperative symptoms of overactive thyroid. *M. D. Prescription: Atomic Cocktail. Your Radiologist. Spring* 1956.

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With the advent of the newer drugs, and the great advance in surgery of the lungs, medical progress has slowly converted tuberculosis from a killing to a chronic disease. This is a great achievement. But, in changing the course from a killing to a chronic state, tuberculosis handicaps its victims, thereby creating a huge financial and emotional problem, which eventually threatens, with its ever increasing size, to stifle the medical economy of our communities. I. Phillips Frohman, M.D., Ohio State M. J., August, 1955.

# CASE REPORTS



# Chlorpromazine in the Management of Psoriasis

ROBERT A. FISHER, M.D., AND JOSEPH LLOYD D'SILVA, M.D., CHICAGO

MANY theories on the etiology and pathogenesis of psoriasis have been postulated: Gruetz[1] and Gans[2] attribute it to anomalies of fat metabolism; Monash[3] to avitaminosis D; Stingily[4] to a deficiency of vitamin B12; and Ingram[5] suggests that hormonal activity may play an important part. Because the proponents of each theory advocate a different therapy, the patient has gone through a gamut of treatment from local therapy, ultraviolet radiation, and dietary regimens to gamma globulin, Aureomycin,® Terramycin,® and ACTH. Although the cause of the disorder is unknown, investigators have observed that psoriasis often is associated with or exacerbated by emotional tension. The following case histories of two psychotic patients whose long standing, generalized psoriasis cleared coincidentally with the amelioration of their psychoses suggests that the etiology of psoriasis may be largely emotional.

### CASE HISTORY NO. 1

A 58 year old white female was admitted to the Chicago State Hospital in 1945, with a history of mental disorder; she was diagnosed as having dementia precox, catatonic type. Admission chest X-ray revealed pulmonary tuberculosis in the right upper lung field. She also suffered from a generalized dermatitis with well demarcated salmon-red areas diagnosed as generalized psoriasis. History of her psoriasis dates back to 1942; since then she had been treated unsuccessfully with various types of ointments and tars.

After treatment with chlorpromazine, which was started in February, 1955, she not only experienced improvement in her mental attitude, but also achieved an almost complete clearing of her skin condition. The dosage schedule necessary to alter the skin condition was much higher than her psychosis required. The following dosage regimen was adopted arbitrarily: 50 mg. t.i.d. increased daily by 100 mg. up to 900 mg. This maximum dose was maintained for three days, then reduced gradually over a period of one week to a maintenance dose of 50 mg. t.i.d. The first noticeable change in her skin condition was a diminution of generalized discomfort and itching which were allayed in three to four days. In about a week to 10 days the lesions gradually began to desquamate, leaving isolated dull red areas at their sites. Further clearing occurred during the high dosage period. Chlorpromazine was discontinued to see if the lesions would recur without therapy. Although less acute, they did recur in two to three weeks. The patient was then restarted on chlorproma-

*From the Chest Service of the Chicago State Hospital, Illinois Dept. of Public Welfare.*

zine with the same beneficial results.

### CASE HISTORY NO. 2

A 55 year old white female was admitted to the Chicago State Hospital in 1945 with a diagnosis of schizophrenia, catatonic type. During her stay in the Chicago State Hospital she developed pulmonary tuberculosis in the right upper lung field. The patient was combative, difficult to manage, and required frequent restraint and isolation. She also suffered from a desquamating skin condition with typical localization on elbow, neck, and head, diagnosed by the consultant in dermatology as psoriasis, and treated as such with unsuccessful results. Later she was put on chlorpromazine for her psychosis, and at the same time received specific combined chemotherapy (PAS, INH, and streptomycin) for her tuberculosis. The chlorpromazine dosage was moderate; it did not exceed 200 mg. daily in divided doses. Toward the end of three weeks, not only was her mental condition dramatically improved but her skin disorder had disappeared. This patient developed jaundice of an obstructive type similar to those cases reported in the literature, accompanied by an elevation of serum bilirubin and alkaline phosphatase. Chlorpromazine was discontinued. In about three weeks the jaundice cleared and, simultaneously, typical desquamating lesions appeared on the elbow and neck similar to those observed prior to chlorpromazine therapy.

### COMMENT

The fact that the psoriasis suffered by these two patients cleared while they were taking chlorpromazine and reappeared when the drug was discontinued suggests that chlorpromazine is effective, or at least helpful, in the treatment of psoriasis. These results demonstrate either that chlorpromazine is a specific treatment for psoriasis, or that psoriasis is primarily psychic in origin, and may be alleviated by reducing the patient's tension and anxiety. Ingram[5] in a review of the social and psychological background of 80 of his patients with psoriasis found emotional stress to be a potent etiological factor. It has been common to prescribe small doses of phenobarbital[6] or to employ psychotherapy[7] in the treatment of this condition.

Recently it has been brought to our attention that rauwolfia serpentina which has the same ataraxic action as chlorpromazine was beneficial in psoriasis[8]. Therefore, it appears the ataraxics are useful therapeutic adjuncts in the treatment of psoriasis. Further investigations would seem justified.

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# EDITORIALS




## Do as I say . . . .

Physicians might be more sympathetic toward their patients if they themselves were ill more often and in need of surgery, gastric analyses, prostatic massages, or proctoscopic examinations.

A famous surgeon of more than a quarter of a century ago routinely ordered large, postoperative proctoclyses administered at a rapid rate. His patients complained bitterly, but orders were orders. The surgeon maintained that this routine lowered the mortality rate in his cases, and it probably did. But when the surgeon in question underwent an appendectomy, his colleagues decided to give him a dose of his own medicine. Thereafter, no proctoclysis of that size and rate was administered in his hospital.

More and more laboratory tests are being introduced. It is surprising how little the average person knows about these procedures and how grateful they are for an explanation on what to expect. They have less anxiety and, in addition, mistaken ideas and erroneous beliefs are dispelled. Many laymen still think that a spinal tap is followed by months of backache and headache and occasionally by numbness, pain, or paralysis of the lower extremities.

Others are afraid of electrocution when the wires of the electrocardiogram are attached to the extremities. The cardiac who has been told to take it easy develops considerable anxiety when asked to do the Master's two-step test. Innumerable tall tales have appeared about isotopes and patients are sometimes ashamed to admit their fears about atomic diagnostic procedures. They appreciate an authoritative explanation.

There is another reason why every physician should be a patient. Some medicos are too liberal with their criticism of habits the public enjoys. This has led to a number of suggested "don'ts." Patients are told blithlely to stop smoking, drinking coffee, or overeating. The number of "don'ts" would decrease if physicians tried to break a few of their own habits or if they went on a low salt or 800 calorie diet. How many members of the profession have tried to exist on fruit juices and rice for breakfast, lunch, and dinner?

It also has been suggested that every physician use on himself the samples of medicine he receives. They might end up by being less liberal in passing out sedatives and tranquilizing agents that make a person so drowsy he doesn't care to work. It is difficult to practice medicine when confronted with this side reaction of many of these drugs yet we expect our patients to carry on normally during treatment with these "don't-give-a-damn" pills.

The best way to get information is to get it firsthand. There is one objection to physicians being patients: They might become too sympathetic and not order certain remedies and procedures even when they are necessary.

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## Increasing farm accidents

In the Aug. 4, 1956 issue of the Journal of the American Medical Association, Dr. Franklin H. Top, Iowa City, pointed out that deaths from

farm accidents in 1954, totalled 14,000, a rate of 61.7 per 100,000 farm residents. Dr. Top stated that the high level of work accidents on the farm is partially due to the shift from horse-drawn to motor-driven machinery. When the farmer stopped having to rest his horses periodically, he also stopped resting himself.

In hot weather during the farming season, horses had to be rested periodically and naturally this gave a rest period for the driver. Unlike motorized farm machinery, horses cannot be used for periods of from 10 to 15 hours a day, and for a number of consecutive days. This failure to observe rest periods and the accompanying fatigue was blamed for many farm accidents.

Another factor which perhaps plays an important part in these considerations, is the difference in retiring hours on the part of the farmer today, as compared with the horse-drawn equipment days. Then, the farmer would usually retire at an early hour after his day's work was done. Today, the average farmer has radio and television in the home, and more time is devoted to some evening entertainment than was previously the case. Today he has all weather, hard surfaced roads which permit him to take his auto for evening trips.

Dr. Top stated that studies show there is a mid-morning and mid-afternoon peak period during which the majority of accidents occur. He believes a mid-morning break, like that given in many factories and offices, would be a good idea for the farmer. Carelessness in the handling of machinery and disregarding the safeguards on modern farm equipment is also a factor in the increasing farm accidents. Those of us living in farming communities have seen many farm workers lose a hand or an arm in the mechanized corn pickers each fall. Printed warnings on the equipment are disregarded, and with the machine running, too often we have seen the results of this type of carelessness.

In this report it was shown that tractor accidents account for 700 deaths a year, and many of these occur on the highways. In one recent study it was shown that approximately one-third of the tractor deaths occur on the highways.

It is obvious that much educational work is required to reduce the number of farm accidents. The Committees on Rural Health can be of much assistance through their associations with farm bureaus and other organizations.

## The treatment of malignant tumors with betatron radiation

*Savages explain, science investigates.*

William Gull.

It is a curious fact that various forms of radiation, notably X-ray and radium emanations, of value in the treatment of some forms of malignant growths, may actually cause cancer if utilized with insufficient precautionary measures. Most of the early radiologists failed to take adequate precautions to protect themselves against the rays and many of them died of cancer. In recent years selective radiation with the isotopes of certain chemicals has been used advantageously, the use of the isotope of phosphorus in polycythemia vera being an excellent example.*

Recently two Swiss physicians, Professors H. R. Schinz of Zurich and A. Zuppinger of Bern, reported results obtained in different forms of cancer from the use of the x-ray emanations given off by the betatron.** They point out that the betatron does not emit continuous x-rays but, in correlation with phases of an alternating current, produces biologically active secondary electrons possessing greater deep penetrability than the primary rays and those given off by x-rays or radium.

Doctor Schinz irradiated 66 patients with carcinoma of the esophagus. Dramatic, more or less lasting improvement occurred in 15 over a follow-up period of 30 months. He irradiated 37 patients with bronchial carcinoma of whom 17 obtained subjective improvement. Of 27 patients with cancer of the bladder, two of eight with inoperable lesions have survived symptom-free for two and a half years. Of 35 patients with carcinoma of the cervix uteri, 15 of whom had had a prophylactic operation, 12 have survived without symptoms. Good results were obtained also in patients with carcinoma of the body of the uterus and carcinoma of the ovary most of whom, excepting those treated prophylactically, had far-advanced inoperable lesions. Doctor Schinz claims that the betatron gives results that 200 kilovolts of irradiation could never achieve in a like period.

Doctor Zuppinger obtained excellent results in

*See Modern Medical Monographs. Polycythemia. John H. Lawrence. Grune and Stratton. New York and London, 1955.

**Letter from Switzerland. J.A.M.A., 159: 212, 1955.

brain tumors and those of the mouth, jaw, and pharynx. Even patients with cancer of the stomach benefited from the treatment. He suggested that preoperative radiation before gastric resection for carcinoma might lead to improved results.

The Swiss radiologists consider the betatron treatment a significant forward step in radiation therapy. While one must agree that their results are definitely promising, it will be necessary to follow effects on more patients and over a longer period before drawing final conclusions. There is, however, enough promise in the method to show that it is one well worth continuing investigation. *G. B.*

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## How should you vote on the blue ballot Nov. 6?

One of the most important votes—to you personally—that you will ever cast will be on the separate Blue Ballot at the November 6 election on the proposed Tax Amendment to the Revenue Article of the Illinois Constitution.

Proponents of the proposed Tax or Revenue Amendment admit that it would give the legislature powers it does not now have to change the whole basis for taxation of real estate; powers it does not now have to classify tangible personal property into any number of classes so long as each such classification is "reasonable and . . . based solely on the nature and characteristics of the property . . .", and to tax or authorize local governments to tax any class (from air conditioners to surgical instruments) at any rate from zero to 100 per cent; powers it does not now have to do the same thing with intangible personal property such as stocks, bonds, and mortgages.

Proponents of the proposed Tax Amendment also admit that it would give the Illinois legislature the power to impose a flat State income tax, and to authorize the City of Chicago or other local governments to impose a flat tax on income from salaries, wages, and professional fees earned within the boundaries of the local government regardless of the place of residence of those earning the income. However, the proponents contend that the Illinois legislature has this power now, under the present Constitution.

This contention is only an opinion of lawyers advocating adoption of the Amendment. It is not a fact. It has never been passed upon by the Illinois Supreme Court. It is an opinion which is not shared by other lawyers, including legal advisors to the Mayor of Chicago according to published newspaper reports. The best evidence of the serious doubts as to the constitutionality of such flat income taxes under the present Constitution is the fact that no such legislation has even been introduced at sessions of the Illinois legislature.

Proponents of the proposed Tax or Revenue Amendment point to the fact that it expressly prohibits a graduated income tax. Under the present Constitution, a graduated income tax cannot be imposed either. The Illinois Supreme Court has so held. But, under the proposed Amendment, the proponents concede that the legislature would have clear authority to impose, and to authorize local governments to impose, a tax at one rate on income from wages, salaries, and professional fees; a tax at a different rate on corporate or business income; still different tax rates on income from stocks, from bonds, from mortgages, and from other intangibles. While the proposed Amendment would prohibit a graduated income tax in words, it would clearly make it possible to approach a graduated income tax in fact.

Although the proponents must concede that the proposed Tax Amendment would give the Illinois legislature crystal-clear powers which it either does not now have at all or which are now doubtful, they contend that we must trust our elected representatives. When we gave Congress unlimited power over income taxes by amendment to our Federal Constitution, we imposed trust in our elected Congressmen not to abuse that power. Why should we invite abuse of power by granting our elected representatives powers any broader than we must? While admittedly there are changes that would be desirable in the present Revenue Article of our Illinois Constitution, those specific changes should be made possible by specific powers given to the legislature, not by giving the legislature a blank check.

Illinois has prospered under its present Constitution. We can continue to prosper under it until it can be changed to suit the people and not the politicians. The tax climate in Illinois —State and local—is in fact one of the most favorable in the nation. Shall we keep it that way?



When F. Lee Stone, President and Harold M. Camp, Secretary of the Illinois State Medical Society presented Louis H. Bauer, President of the American Medical Education Foundation with this $164,940 check at the recent A.M.A. meeting in Chicago, Dr. Bauer described it as "the largest received from any state society since the Foundation was organized." "Largest" has two meanings in this instance.

## Volume II, History of Medicine in Illinois

The Secretary's office has received a number of requests for volumes of the recently published second edition of the History of Medicine in Illinois. One county medical society recently ordered 12 copies of this book as well as a similar number of volume I, which was published in 1927 under the editorship of Dr. L. H. Zeuch. These books were presented to schools and libraries in the county.

Several physicians have order copies, as many as five in some instances, which were similarly presented to schools and libraries. The Woman's Auxiliary to the Illinois State Medical Society has a special committee to aid in the distribution of this interesting book throughout Illinois. Their most recent recommendation is incorporated in the following statement as received at the Secretary's office.

"Now is the time to think of Christmas gifts to avoid the rush that is characteristic of the season. Please include in your list Volume II of the History of Medicine in Illinois. This volume has interesting reading material which doctors particulary will appreciate. It is a lifetime gift and a memento of the inheritance of the doctors practicing medicine in Illinois today. It is a suitable gift to hospital libraries, medical students, interns, residents, practicing physicians, specialists and to laymen interested in the practice of medicine in Illinois.

"The price is $10.00 and copies may be obtained by writing to the Secretary, Illinois State Medical Society, Medical Arts Building, Monmouth, Ill."

Anyone desiring a copy of this interesting book may procure same by following the above recommendation.

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## 181st anniversary of the Army medical service

The Army Medical Service celebrated its 181st anniversary on July 27, 1956, with a group of 61,000 physicians, nurses, medical specialists and enlisted men. It has long pursued a vigorous research and development program in order to better safeguard the health of the American soldier. The civilian population has also benefited through this research program.

Each year the Armed Forces suffer approximately 2,000 deaths from automobile accidents plus a large number of man-days lost due to injuries. As a result of these investigations, the automobile manufacturers came up with safety door latches and seat belts made optional in many 1956 car models. Another discovery through these research programs has developed the preventive treatment of Q fever, previously seen frequently in stock handlers, slaughterhouse workers and others who come in contact with livestock.

The Army Medical Service researchers have also been aiding in the development of other discoveries which have materially improved the care of soldiers as well as our civilian population. The Service may be proud of its contributions to civilian medicine and to improvements in American health over the past 180 years.

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John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

# Emergency Treatment in Urban and Rural Communities

W. W. Fullerton, M.D., Sparta

IT IS generally known that from time immemorial man has become an increasingly gregarious individual — anxious to work, play and be in company with other people. The very fact of living has led to crisis such as accidents, battle wounds, births, deaths, illness and disaster. Disaster, individual or mass, is an accepted part of life and always has been. To cope with a disaster, man has always called upon his neighbors, friends and relatives; also, people have come forward spontaneously to help him. However, the complications of modern living have made a lot of difference as to when and how accidents and emergencies occur, and the manner in which they are disposed of.

There is a lot of difference today with our modern roads, automobiles, and modern medicine in contradistinction to our forefathers, not too many generations removed, when we relied upon the old horse and buggy ways of doing things. The writer wishes to take this opportunity to relate a story told by Dr. Henry Horstman of Murphysboro, a former Councilor of the Illinois State Medical Society. He related this particular instance in which he was making a house call, presumably about eight miles west of Murphysboro, and received a telephone message that someone had had his arm cut off and was bleeding profusely. The man lived eight miles from Murphysboro in an opposite direction so that the trip involved sixteen miles of travel. This occurred, probably fifty years ago. He telephoned his office or home and advised them that he would have to have a change of horses and to have the other rig and other team hitched. He drove the team that he was using at a gallop into Murphysboro, changed horses, and galloped eight miles again with a new team. The emergency was not an amputation of an arm as he had been led to believe, but an amputation of a thumb, and some intelligent farmer had finally applied pressure to the bleeding appendage and the bleeding had stopped. This story we are quite sure is not exaggerated and is being told to illustrate two points: first, even with our modern conveniences of travel and good roads, a doctor cannot always be immediately on the spot to meet the first treatment of the emergency; secondly, the necessity of some responsible layman knowing what to do until the doctor gets there.

We have come a long way in educating various crews, and particularly in industry, in the handling of emergencies. The power companies, with their high-voltage lines with which they work daily, have intensive courses in first aid treatment, particularly in artificial respiration, and

some of these crews are extremely well trained. The powermen do not give up on these electrocutions. There is one industry which, although needing a lot af training today, is much better prepared emotionally and much more alert to emergencies than it used to be; this is the farm group. It has become a necessity, almost for their survival, to learn something about the general rules of safety. Farming has, of all vocations in the short period of some twenty-five or thirty years, gone through a transition from horse power to electrical and motor power. The little farmer practically does not exist anymore. Farming is practically a mechanized industry in itself. However, it is still the individual farmer who is the boss and laborer, and it is in this group that we perhaps need to encourage more training and more first aid, with more emphasis paid to safety devices and safety precautions.

Industry as a whole has become one complicated and mechanized city within itself. Industries large enough employ surgeons or have arrangements with trained industrial surgeons to take care of their injured; as well as a bevy of nurses and crews trained in first aid. Some of this has been the demand of labor organizations, and some has been due to the foresight of the industry itself and the safety expert in industry. Most large industries have a department whose business it is to be on the lookout for safety devices and to promote and arrange for first aid training.

The inclination of doctors to locate in the large communities and their tendency toward specialization has led some of the rural communities to be short of medical personnel in time of emergency. However, this is probably stressed too much. The actual lack of professional coverage is exaggerated by the public press and individuals, labor unions, and industrial management. When an emergency arises and help is needed, it is expected to get an immediate response from the medical personnel. However, as mentioned above, the training of first aid units is a necessity to offset any delay that may occur as a result of a late-arriving doctor. There are probably no doctors anywhere who can be absolutely ready to jump at the first minute of the reception of a call of emergency. Furthermore, every doctor who is located in a rural community or even in an urban community, even though he may be a specialist, should make provision in his office to handle emergency treatment with efficiency. Even if he is a specialist there are many emergencies that come up that can well use the efforts of a specialist, as sometimes no one else is available.

Therefore, in order to alleviate some of the embarrassment that might befall the injured and the professional people responsible for taking care of them, the training of lay personnel in safe first aid methods is a necessity and we will mention a few of them: (A) The power companies, which for all practical purposes and for the type of emergencies they are apt to receive, are probably ahead of all other industries. (B) The fire department should have, and most of them do have within their training periods, carefully skilled members trained in the art and use of all of the safety and first aid devices, and carry much first aid equipment with them on their runs. However, fire departments in the rural areas are often volunteer men, and it is probably prerogative that more stress should be placed on the training of these volunteers. (C) Farm education: It is characteristic of farmers and their neighbors to work together more or less in neighborhood groups. These various neighborhood groups should be encouraged through their health improvement associations to have their own individual first aid teams and all of them should be given general instructions as to safety devices. (D) Most ambulances, even in rural communities, have oxygen equipment but too often they don't know how to use it or the equipment is not in working condition. What to do in the case of emergency? What to do before the doctor arrives? Ambulances should be provided with oxygen equipment which is in working order. (E) Mine operations is another industry which has stressed safety for many years and as a general rule they have their first aid teams pretty well developed. However, their type of disasters are sometimes beyond the scope of lay personnel and lay comprehension. Therefore, in coal mine areas when an emergency call comes from a coal mine it is almost imperative that the physician answer that call as quickly as possible. (F) It has already been mentioned that many large industries have a department of safety personnel. However, in some of the smaller industries there is still a lag in the

development of training of people responsible for handling first aid intelligently. (G) Police and highway patrolmen: It is quite obvious that much first aid care is needed in our highway accidents. It is hard, and almost an imposition to ask police and the highway patrolmen to assume the responsibility of first aid when they are called to the scene of an accident. It is their job to patrol the area, police the area and protect the victim from well-wishers, curiosity seekers and the control of traffic in order to avoid further hazards. However, there is a definite lack of first aid training and in the management of highway accidents. There is a further need of coordinated effort between the civil defense people and the various component and first aid teams of industry, the public at large and our police departments.

Insurance companies would profit immensely if they would get together and help in the development of first aid teams in general throughtout rural areas. There needs to be a professional adjustment of attitudes in the medical profession as a whole to the need of improvement in the first aid care of the injured, particularly of the highways. Therefore, it is quite obvious, if we are to improve the care of the emergencies in the rural and urban communities, there must be professional leadership. This can be accomplished: First, as a part of the school program to train our children, especially our high school children, in the simple rules of first aid. Second, it can be accomplished in the Boy and Girl Scout work. Third, those of us who have industrial connections should help industry. Fourth, those of us who live in rural communities and farm areas and those of us who belong to the Farm Bureau Association can work with them and through the efforts of the Health Improvement Association develop first aid teams in the various farm units and home bureau units and set up teams for emergency care. Fifth, local hospital coordination is needed, a first aid room with a first aid kit equipped with materials and supplies for emergency care of almost any conceivable emergency, from snake bites to cardiac; and someone to check that these emergency chests are always in working order and stocked. Sixth, there should be a local physicians' roster for emergency, and the doctor taking his turn on emergency care should always be available for emergency work and the public should know how to contact him; and for him to be reminded a week or two in advance that his week is coming up so that he will not plan to be out of town or have his time committed so that he cannot do his turn of emergency care. Seventh, encourage Red Cross first-aid training. Eight, wider use of safety devices in automobile construction.

We also want to take this opportunity to make some comment in reference to our rising national death toll on the nation's highways. There are a lot of figures quoted and a lot of excuses made and a lot of figures as to what the primary factors are involved in highway accidents. Many lead to death and many people are permanently disabled following them. It seems as though the medical profession has not taken much professional leadership in trying to solve this problem. There should be initiated some understanding of what careless driving consists of. Speed is not always a problem, but speed injudiciously used is a problem. The open highways often appear to be an inviting racetrack. However, all highways have country roads from which a vehicle may approach and inadvertently come upon the highway without stopping to look or listen. Small towns have living individuals in them, just as much as large communities and no residential area, regardless of whether or not it is incorporated, should suffer from a race track of speed-crazy drivers. The State of Illinois, particularly, needs to stress more strongly the prosecution and handling of drivers under the influence of alcohol. True enough, someone having had one or two drinks is not necessarily drunk; however, a change in the terminology applied to the individual involved in a traffic violation or a highway accident is needed. Drivers are brought into a physician and the decision "is he drunk or is he not drunk" is requested, but this is not a very good classification of the degrees of alcoholism. The law probably should say specifically that if there has been one drink taken before a traffic violation, regardless of what the violation is, there should be a good stiff fine.

A second category could be someone not necessarily drunk, but definitely under the influence of intoxicating liquors; his fine should be proportionately heavier, still not labeling the man as intoxicated and, thirdly, the classification of the drunk which can be confirmed either by behaviour patterns or definite laboratory findings.

There should be a closer correlation between speed and alcoholism and emphasis made on fines assessed and punishment applied to the alcoholic whether he has been involved in an accident or not and particularly so if he has been involved in a fatal accident. Some states have laws in which if the driver has been known to have taken any drinks he is automatically subject to a fine regardless of whether or not any accident or violation has occurred. This would have a tendency to induce parties to see that at least one of their members, the driver, did no drinking. There is another thing that needs to be done in Illinois and that is to take the highway patrolman's position completely out of politics; provide a training school for the men who do the police patrol work and guarantee them a job which will not change with every political change that comes along; with opportunities for promotion; opportunities for increase in pay according to the service they render. A police system on the basis of political merit, rather than ability, is not an adequate police system. Proper policing of our nations highways with authority of the patrolman to act and more enforcement of speed laws and enforcement of regulations concerning reckless and inconsiderate driving will do much to reduce our nation's highway death toll and help to reduce the need of emergency treatment in urban and rural communities.

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## What's the diagnosis?

The Blue Cross files contain some interesting material, the instance forming the basis of this report being an example. No inference is made, the report being submitted because it is believed that it will be of interest to the profession.

Between January 3, 1955 and May 9, 1956, a female Blue Cross member, married, age 36, was admitted to the same hospital 26 times. Total cost to Blue Cross was $3512.00. The following summary includes the length of stay, procedures performed and the diagnosis for each admission:

| Admission Date | Length of Stay | Diagnosis and Procedure |
|---|---|---|
| 1-3-55 | 7 day stay | Cholecystitis |
| 1-14-55 | 15 day stay | Cholecystitis (chronic)—cholecystectomy |
| 2-1-55 | 7 day stay | Acute hepatitis |
| 2-18-55 | 5 day stay | Strictures right ureter—cystoscopy and dilatation right ureter |
| 3-18-55 | 5 day stay | Stenosis and kink of right ureter |
| 3-25-55 | 5 day stay | Renal colic due to stricture of right ureter—cystoscopy |
| 4-7-55 | 27 day stay | Cystic ovaries—fibrous uterus—adhesions; total hysterectomy—bilateral oophorectomy |
| 5-16-55 | 7 day stay | Postoperative bleeding with pain in left side of pelvis plus right ureter stricture and kink |
| 5-24-55 | 6 day stay | Kink in the right ureter |
| 6-5-55 | 11 day stay | Postoperative hematoma following hysterectomy—ureteral colic |
| 6-17-55 | 12 day stay | Contusion and sprain left hip |
| 7-5-55 | 5 day stay | Renal colic—cystoscopy; influenza |
| 8-7-55 | 2 day stay | Renal colic—stricture and kink right ureter |
| 9-16-55 | 6 day stay | Renal colic—stricture right ureter—cystoscopy |
| 11-7-55 | 6 day stay | Renal colic—stricture and kink right ureter—cystoscopy |
| 11-25-55 | 6 day stay | Renal colic—stricture and kink right ureter |
| 12-6-55 | 8 day stay | Lysis of adhesions |
| 12-28-55 | 7 day stay | Cardiospasm |
| 1-5-56 | 18 day stay | Pylorospasm |
| 2-2-56 | 5 day stay | Acute gastritis |
| 3-3-56 | 5 day stay | Influenza |
| 3-15-56 | 3 day stay | Acute tonsillitis—acute cystitis |
| 3-23-56 | 5 day stay | Acute cystitis |
| 3-31-56 | 6 day stay | Acute cystitis |
| 4-10-56 | 2 day stay | Postoperative check; cystoscopy and retrograde pyelogram |
| 5-9-56 | 5 day stay | Acute gastroenteritis |

# CORRESPONDENCE



## North Shore Health Resort lecture series

We are happy to anounce the Seventh Annual North Shore Health Resort Lecture Series for the 1956-57 season. The theme is The Medical Practitioner's Contributions Toward Healthy Emotional Development.

As in the past, the lectures are presented as a public service to the physicians of the Chicago area on the first Wednesday of each month (except January and May) at the hospital, 225 Sheridan Road in Winnetka, Illinois at 8:00 p.m.

The J. B. Lippincott Company has agreed to publish this series as a book in 1957. The Board of Directors of the North Shore Health Resort and the individual authors have assigned all royalties from the sale of this book to the American Psychiatric Association. The American Academy of General Practice will again give its members credit for attendance at these lectures. All physicians and allied professional personnel are cordially invited to attend. The program follows.

Oct. 3, 1956. The Unique Position of the Physician in Our Society. Daniel Blain, M.D., Medical Director, American Psychiatric Ass'n., Clin. Prof. of Psychiatry, Georgetown Univ.; Consultant, Vet. Adm.; Member, Expert Committee on Mental Health of the W. H. O.

Nov. 7, 1956. The Psychological Preparation of the Individual for Medical and Surgical Care. Milton Rosenbaum, M.D., Professor and Chairman, Department of Psychiatry, Albert Einstein Col. of Med.; Dir. Psych. Services, Bronx Municipal Hosp. Center; Chair. Com. on Medical Education, A. P. A.

Dec. 5, 1956. Problems of Early Development. Lauretta Bender, M.D., Prof. Clin. Psychiatry, New York Col. of Med.; Principle Research Scientist in Child Psychiatry, Dept. of Mental Hygiene, State of New York.

Jan. 9, 1957 (Second Wed.). Problems of the School Child. Ralph D. Rabinovitch, M.D., Director, Hawthorne Center, Consultant in Child Psychiatry, State Department of Mental Health, Northville, Michigan.

Feb. 6, 1957. Problems of Teenagers. Frederick H. Allen, M.D., Director, Philadelphia Child Guidance Center; Clin. Prof. Psych., U. of Penn.; Pres. Amer. Acad. of Child Psych.; Past Pres., Inter. Ass'n. of Child Psychiatry.

Mar. 6, 1957. Problems of Adulthood. C. Knight Aldrich, M.D., Professor and Chairman, Department of Psychiatry, University of Chicago School of Medicine.

Apr. 3, 1957. Premarital Counseling. Emily H. Mudd, Ph.D., Director, Marriage Council of Philadelphia; Ass't. Prof. Family Study, Dept. of Psych., School of Med., U. of Penn.

May 8, 1957 (Second Wed.). Marriage Counseling. Robert W. Laidlaw, M.D., Chief, Div. of Psychiatry, The Roosevelt Hosp., Past Pres. Amer. Acad. of Marriage Counselors.

June 5, 1957. Problems of Grandparents. Erich Lindemann, M.D., Professor of Psychiatry, Harvard Medical School, Psychiatrist-in-Chief, Mass. Gen. Hosp.; Medical Director, Human Relations Service, Inc.

Samuel Liebman, M.D., Medical Director.

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## Clinics for crippled children listed for October

Twenty clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois Division of Services for Crippled Children. The Division will count 14 general clinics providing diagnostic ortho-

pedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 2 for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The October clinics are:

October 2 - Quincy, Blessing Hospital

October 3 - Hinsdale, Hinsdale Sanitarium

October 9 - E. St. Louis, Christian Welfare Hospital

October 9 - Peoria, Children's Hospital

October 11 - Cairo, Public Health Building

October 11 - Elmhurst Cardiac, Memorial Hospital of DuPage County

October 11 - Springfield, St. John's Hospital

October 12 - Chicago Heights Cardiac, St. James Hospital

October 16 - Danville, Lake View Hospital

October 17 - Alton (Rheumatic Fever), Alton Memorial Hospital

October 17 - Chicago Heights General, St. James Hospital

October 18 - Flora, Clay County Hospital

October 18 - Rockford, St. Anthony's Hospital

October 23 - Peoria, Children's Hospital

October 24 - Elgin, Sherman Hospital

October 24 - Springfield (Cerebral Palsy), Memorial Hospital

October 25 - Bloomington (A.M.-General, P.M.-Cerebral Palsy) St. Joseph's Hospital

October 25 - Mt. Vernon, Masonic Temple

October 26 - Chicago Heights Cardiac, St. James Hospital

October 30 - Effingham (Rheumatic Fever), St. Anthony's Hospital

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The use of the tranquilizing drugs, chlorpromazine and reserpine, has increased the number of discharges of former chronically ill mental patients by 36 per cent in a Massachusetts VA hospital.

## Fall Conference of the Woman's Auxiliary

for

County Presidents, Presidents-Elect, Officers and Committee Chairmen

Members and Guests are cordially invited to attend

October 25-26, 1956

Chicago

Sheraton-Blackstone Hotel

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Thursday, October 25

a.m.

8:30-10:00

Registration .....Crystal Ballroom

9:30

Call to Order ....Mrs. Nicholas G. Chester, Chairman of the Conference

Auxiliary Pledge ..Mrs. James P. Simonds

Welcome .....Mrs. Matthew E. Uznanski

Response .....Mrs. Neal D. Crawford

Greetings ...F. Lee Stone, M.D., President Illinois State Medical Society

Introduction of National President .... ..... Mrs. Robert E. Dunlevy

Introduction of National President .... ..... Mrs. Robert Flanders

Program

10:00

Public Relations .....Mr. Leo E. Brown

Rural Health .....Harlan English, M.D.

Legislation .....Mr. Walter L. Oblinger

"History of Medicine in Illinois" ..... ..... James H. Hutton, M.D.

Mental Health ....F. Garm Norbury, M.D.

Safety...Speaker, National Safety Council

Luncheon, Mayfair Room

Guest Speaker ....Mr. Henry Viscardi, Jr.

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Friday, October 26

10:00

Panel Discussions .....Crystal Ballroom

Presiding .....Mrs. Fred C. Endres, Co-chairman of the Conference

Participating .....County Presidents

12:00 noon

Adjournment .....

p.m.

1:30

Board of Directors Meeting .....Ivy Room

## To headline annual fall conference

On October 25th, 1956, the Woman's Auxiliary, during their Fall Conference at the Sheraton-Blackstone Hotel, proudly presents an outstanding speaker in the field of rehabilitation, Mr. Henry Viscardi, Jr. Coming to Chicago from West Hempstead, New York, Mr. Viscardi, a member of the President's Special Committee on Rehabilitation, will present his story of what has been accomplished in this important field.

'Hank' Viscardi, born legless, has devoted the greater number of his forty four years to bring dignity to those suffering severe disabilities. His recent testimony before the Senate inquiries on Pensions for the Disabled gives further proof to his philosphy, "Think only of a man's ABILITY, not his DISABILITIES." He insists, "Instead of parades, pensions, and pity, handicapped people want the opportunity to live productive lives, and to support their families in dignity." Although severely handicapped himself, Mr. Viscardi testified against pensions and support by federal aid.

During World War II, after having been rejected by the Armed Services, Hank Viscardi volunteered, and was finally accepted by the American Red Cross, after amazing those who observed his ability to drill, and keep up with those not handicapped in any way. During these years, as a member of the Red Cross, Mr. Viscardi was sent to many veteran's hospitals throughout the United States to help rehabilitate those who had lost their limbs during the War. In keeping with his promise to Dr. Robert R. Yanover, the surgeon who had performed countless operations on Hank Viscardi, he relinquished an extremely well paying position with the Burlington Mills, in 1947 to head JOB. JOB [JUST ONE BREAK] was formed with Bernard M. Baruch, Bernard F. Gimbel, Eleanor Roosevelt, and many other notables, to find employment for the handicapped. It was part of the New York University-Bellevue Institute of Physical Medicine and Rehabilitation. When accepting this important position as director of JOB from Colonel Howard A. Rusk, Hank Viscardi was fulfilling his word to dedicate his life to helping others, which is the promise he gave to Dr. Yanover, as payment for his services. In the doctor's own words, he said in refusing medical payments for his surgical services to Mr. Viscardi, "There is no bill Hank, but someday when you get the chance, do something to help other cripples. Then our account will be settled." Not satisfied to just head the important post with JOB, Hank Viscardi started his own electronics firm, producing important war materials for the Korean War. This company began with four men, who, between them had seven arms and one leg. Today, this firm called ABILITIES, INC. employs almost two hundred persons, all severely handicapped. Mr. Viscardi is married to the former Lucille Darracq, and is the father of four daughters.

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## Officers of the Illinois Trudeau Society

At the annual meeting of the Illinois Trudeau Society held in Springfield, the following officers were elected for the fiscal year.

Ernest Teller, M.D., President, Chicago; George H. Vernon, M.D., President-Elect, Edwardsville; Karl H. Pfuetze, M.D., Secretary-Treasurer, Chicago.

Dr. Teller is in charge of tuberculosis control, Illinois Department of Welfare. Dr. Vernon is Medical Director and Superintendent of the Madison County Tuberculosis Sanatorium. Dr. Pfuetze is Medical Director and Superintendent of the Chicago State Tuberculosis Sanitarium.

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## American Fracture Association meeting

The 1956 annual meeting of the American Fracture Association will be held at the Drake Hotel, Chicago, November 29, 30, and December 1. The Association has also scheduled an instruction course in fractures in conjunction with the Cook County Postgraduate School to be held on the day preceding the opening day of the meeting.

Complete programs and information concerning the Fracture Association meeting may be procured from the Secretary-General, H. W. Wellmerling, 610 Griesheim Building, Bloomington, Illinois.

## A letter to student nurses

This letter may prove to be the most important you have ever received! So, please read it carefully. If it is not of interest to you personally, it may be of vital importance to some relative friend or neighbor.

The current academic year of most nursing schools will shortly end. For those who will be graduating, important decisions must be made regarding plans either for immediate employment or for graduate training in your chosen profession.

If you are seeking employment, the Department of Public Welfare has many interesting and challenging opportunities open for you. If you are considering graduate training, the enclosed announcement could change your life.

For student nurses entering their junior or senior year this fall, there are new responsibilities and obligations which will demand your attention shortly.

Therefore, we want to advise all of you who will be senior and junior students that there are a limited number of scholarships available to assist you in finishing your training right in your present school of nursing, if it is an approved school.

We are enclosing an announcement of signal value to all student nurses in basic training, outlining our scholarship plan, its benefits and opportunities. Study it carefully and pass it on to someone else interested in nursing.

If any of the opportunities which are offered appeal to you, please write at once for full details and information.

Sincerely yours,
Otto L. Bettag, M.D.
Director

*Special Announcement For Student Nurses And Graduate Nurses In Illinois*

The 69th General Assembly passed and Governor William G. Stratton signed a Bill last summer making funds available for Nursing School Scholarships through the Illinois Department of Public Welfare.

Approximately 200 scholarships will be awarded for the fall term of 1956 in the field of basic nurses training. Training grants with liberal monthly stipends are also available for graduate nurses to continue their training toward either the bachelor's or master's degrees.

*Special Scholarship Report As Of August 1, 1956*

As of August 1, 1956—the major portion of the scholarships available for basic nurses training have been awarded—*however, special consideration will be given any applications by student nurses entering their junior or senior years of training in either the diploma or degree program.* A summary of the benefits and opportunities is as follows:

*Senior Students*—$600.00 in cash during your senior year, plus any tuition, fees, books and uniforms (Approximately 40 scholarships available for the state for students entering their senior year. Apply now! First come—first served!)

*Junior Students*—$1080.00 in cash during the next two years, plus tuition, fees, books and uniforms (Approximately 10 scholarships available for Illinois students entering their junior year.)

*Beginning Students*—$1440.00 in cash during the next three years, plus tuition, fees, books and uniforms (Extremely limited—but, a few available yet.)

*Students In Degree Programs*—All of the above scholarships are available for students in college or university programs of nursing during their last three years.

*Your Obligation Will Be*: The acceptance of employment at *full salary* as a staff nurse in one of the department of public welfare's psychiatric hospitals or schools (on civil service status, with all rights, privileges and opportunities of same) on a basis of one year of employment for each year in school on the scholarship.

*Attention—All Graduate Nurses*

Special training grants are currently available for graduate nurses to continue their training toward either the bachelor's or master's degrees. All applications from qualified graduate nurses will be considered by the department of public welfare. (Fields of study for which these grants are available include psychiatric nursing, nursing administration and nursing education.)

*Benefits Include*: $175.00 a month stipend, with an additional $15.00 for each unemployed dependent up to a maximum of $235.00; plus tuition and academic fees in the fully accredited college or university of your choice in the United States; travel expenses for one round trip from your home to the school permitted each year.

*For full details or further information—write or call* Nursing Service, Illinois Department of Public Welfare, 403 State Office Building, 400 South Spring Street, Springfield, Illinois, phone: Springfield 6611—Ext. 464; 1500 State of Illinois Building, 160 North LaSalle Street, Chicago 1, Illinois, FInancial 6-2000-Ext. 624, 625.

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## University of Michigan Alumni Conference

More than 600 medical alumni of the University of Michigan Medical School will meet in Ann Arbor, September 27-29 for their Triennial Medical Alumni Conference. A special program of scientific presentations, panels, and clinics will highlight the scientific portion of the program, while a banquet, special convocation of the U-M Medical School, and the Michigan-UCLA football game will feature the pleasure side.

Th sixth such conference of its kind since 1938, Dean A. C. Furstenberg of the U-M Medical School cordially invites every Michigan Alumnus to attend. Information on housing and program reservations can be obtained by writing to A. C. Furstenberg, Dean, University of Michigan Medical School, Ann Arbor, Michigan.

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## Announcement of the Van Meter Prize Award

The American Goiter Association again offers the Van Meter Prize Award of $300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in the Hotel Statler, New York, New York, May 28, 29 and 30, 1957, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations, should not exceed 3,000 words in length and must be presented in English. Duplicate typewritten copies, double spaced, should be sent to the Secretary, Dr. John C. McClintock, 149½ Washington Avenue, Albany 10, New York, not later than January 15, 1957. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for the presentation of the winning essay by the author if it is possible for him to attend. The essay will be published in the annual proceedings of the Association.

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## Pan-Pacific Surgical Association

The Seventh Congress of the Pan-Pacific Surcal Association will be held in Honolulu, Hawaii November 14-22, 1957. All members of the profession are cordially invited to attend and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program by leading surgeons with sessions in all divisions of surgery and related fields promises to be of interest to all doctors.

Further information and brochures may be obtained by writing to Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Room 230, Young Building, Honolulu, Hawaii.

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## Recent grants to the Hektoen Institute

The Damon Runyon Memorial Fund for Cancer Research has allocated a grant of $12,000.00 to the Hektoen Institute for Medical Research of Cook County Hospital, for studies in leukemia under the direction of Dr. Steven O. Schwartz and his associates. This is the second yearly grant that the organization has given the Institute. The Department of Health, Education and Welfare, Public Health Service has granted $16,160.00 for studies on relations of timing and bacteriology of superimposed pyelonephritis in the course of chronic glomerulonephritis under bacteriologic and immunologic group A streptococcal control. This work is to be done by Drs. Daniel S. Kushner, David P. Earle, Jr., and S. Howard Armstrong, Jr.

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# THE P. R. PAGE

**Edward A. Uzemack, Director of Public Relations**

THIS month's PR Pat-On-The-Back goes to the Chicago Medical Society for an extraordinary effort in dealing with Chicago's polio emergency.

Faced with a situation in which the city was experiencing the most severe outbreak of polio in its history, the Society's president, Dr. Karl A. Meyer, arranged a meeting of its branch presidents and past presidents with city, county and state health officials. Out of this meeting came an emergency plan for mass inoculation of all children under the age of 20 and pregnant women.

Members of the Chicago Medical Society were asked to urge their respective hospitals to set up special polio clinics where the inoculations could be given free of change. The physicians agreed to contribute their services. It was estimated that approximately 500,000 persons had to be inoculated before mid-August.

Sixty-four Chicago area hospitals agreed to participate in the CMS-inspired program and the first clinics were in operation four days after the meeting. The polio vaccine was obtained from the Chicago Health Department and extra supplies of needles and syringes were provided by the Cook County Chapter of the National Foundation for Infantile Paralysis. The Woman's Auxiliary to the Chicago Medical Society, the Red Cross and the National Foundation supplied much voluntary clerical help for the necessary record-keeping.

The Illinois State Medical Society's public relations director was commissioned to handle the publicity for the campaign, and staff members of the ISMS Chicago office pitched in by keeping daily tabulation of inoculations at each of the hospitals. All radio and television stations in the area were asked to carry a spot announcement which urged parents to call the CMS and ISMS headquarters for information on where there was a free polio clinic nearest their homes. The city's newspapers carried a complete listing of the hospitals for several days and a special "box" with the telephone numbers of the state and county medical societies.

In the first two weeks of operation, more than 175,000 youngsters and pregnant women were inoculated under the CMS program.

Favorable editorial comment in the Chicago newspapers resulted almost immediately. The members of the Chicago Medical Society also received praise for a good piece of public relations work in the Secretary's Letter of the American Medical Association. This is the type of activity by a medical organization that the public will remember favorably for a long time to come.

PR GRAFS—

The American Medical Association's new 30-minute color movie, "The Case of the Doubting Doctor," is now available for use by county medi-

cal societies. The 16 mm film is designed to acquaint physicians with the services and activities of their national organization. County societies can arrange to borrow this film by writing directly to the AMA Film Library, 535 North Dearborn Street, Chicago 10, Illinois, or to the ISMS Public Relations Director, 185 North Wabash Avenue, Chicago 1, Illinois. . . At a Public Relations Workshop at Utica College, N. Y., Professor Scott M. Cutlip of the University of Wisconsin declared: "Too much of today's PR thinking and practice puts the emphasis on telling the people, getting the people to understand us and our problems . . . far too little effort is made to understand the public—its ideas, its needs and its aspirations . . . Before there can be rapport, there must be empathy."

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## Tests for viruses

These are exciting days for the application of diagnostic methods to virus diseases, and the period is comparable to 40 or 50 years ago, when new bacteria were constantly being discovered. The etiology of many diseases was then clarified by the introduction of new methods for studying the morphology and cultural appearances of bacteria. In virology today, the introduction of new methods is having a similar effect and we are witnessing advances without parallel in the history of the subject. Foremost among these diagnostic methods are the new techniques of tissue culture, which are rendering obsolete the time-honored methods of isolating viruses by inoculation of eggs and animals. Tissue cultures are particularly suitable for this purpose because they are sensitive to a wide range of viruses. The tissues and other materials can be obtained readily from human operation material or from monkeys, and many ingredients can be obtained commercially. When viruses grow in the cells of tissue cultures, they produce a characteristic degeneration, or cytopathogenic change. Other lesions include the formation of giant cells and nuclear or cytoplasmic inclusions. The finding of such changes enables the virologist to offer a presumptive diagnosis based on recovery of virus from pathologic specimens. The responsibility of deciding whether this virus is the cause of the current illness falls on the attending physician. The isolation of diphtheria bacilli from a throat swab, for example, does not necessarily mean that the patient is suffering from acute diphtheria; he may only be a carrier. In the same way, the isolation of polio virus from a stool of a sick child does not necessarily signify acute polio. However, in the presence of a consistent clinical picture, virus isolation affords strong presumptive proof of the accuracy of the clinical diagnosis. Serologic tests on acute and convalescent sera still occupy an important place, especially in research studies and in the investigation of new diseases. A fourfold or greater increase in neutralizing or complement fixing antibody indicates that the virus has proliferated to a considerable extent, and probably is, therefore, responsible for the current illness. *A. J. Rhodes, M.D. Recent Advances in the Laboratory Diagnosis of Virus Infections. Ann. Int. Med. July* 1956.

# AT THE EDITOR'S DESK



Atomic medicine comes into the cigarette-lung cancer picture. The radioactive content of the tobacco ash is now being blamed.

Estrogenic substances will be recommended shortly for treating male infertility. The rationale can be likened to a rebound phenomenon. The estrogens cause marked depression of spermatogenesis but "there was a surprising resurgence of sperm output when treatment was withdrawn." An improvement in sperm count occurred in 19 out of 24 patients; eight pregnancies resulted and the wife of one patient had two miscarriages.

The stopped heart operation is a revolutionary technique. If successful, it should benefit many of the 50,000 children born annually with malformed hearts. It involves the use of a heart-lung machine but it is tricky "like repairing an automobile engine while it is running."

In the new drug department, we have Preludin, an entirely new synthetic sympathomimetic antiobesity compound. According to Geigy Pharmaceuticals, the product does not destroy the patient's normal relish for food but causes earlier satisfaction of appetite with lesser caloric intake. The manufacturer claims that Preludin combats fatigue without leading to such side effects as palpitation, jumpiness, and insomnia.

Placquenil, a new [Winthrop] antimalarial compound, was found effective in three forms of lupus erythematosus.

Mikedimide made its debut as an effective barbiturate antagonist. According to a release from the Panray Corporation, it restores the patient "quickly and safely from the anesthetized to the wakeful state." In the field of veterinarian medicine "Mikedimide promises to fill the need for the product than can control barbituate anesthesia, hasten ambulation of the animal after surgery, and thereby avoid many secondary respiratory and circulatory complications."

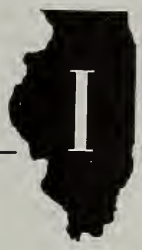
Hoffman-La Roche Inc. has come out with a multivitamin cream (Tashan) for the relief of irritation, pain, and itching in a variety of skin disorders ranging from prickly heat to detergent rash.

The largest single allotment of polio vaccine passed out by the Public Health Service was made in June when a total of 17,172,396 cc. was released. By this time, it is estimated that in all close to 85,000,000 cc. will have been released.

There was excitement in another section of the Health, Education, and Welfare Department. In June, the Food and Drug Administration, through federal court seizures, removed nearly 200 tons of unfit food from the market. Ten tons consisted of beans contaminated with a fluorine rat poison; the rest was filthy and decomposed. An additional ten tons of food were seized to protect the consumer's pocketbook.

The Franklin Hospital Equipment Company has a new tilt bed. It is adjustable from 10 degrees Trendelenberg through full standing (90 degrees) plus all the standard hospital bed positions and adjustments.

# NEWS of the STATE




## ADAMS

**Twenty-Five Years as Health Officer.**—Dr. Harry O. Collins recently completed twenty-five years as health officer, first of the city of Quincy and subsequently of Adams County when the two merged, the Quincy-Herald Whig reported July 15. In his fifty-ninth year of active practice as a physician, Dr. Collings became health officer of the Quincy Public Health District in June 1931 and became director of the entire county health program when the Quincy unit merged with the Adams County Health Department in April 1948. Since 1914, Dr. Collins has been a member of the staff of St. Mary Hospital, becoming president of the staff in 1943. He served as president of the Adams County Medical Society in 1942.

## CHAMPAIGN

**Physician Wins Essay Award.**—Dr. Martin A. Seidell, a member of the internal medicine staff, Carle Hospital Clinic, Urbana, has been named first place winner of the 1956 Mississippi Valley Medical Society Essay Contest for his paper entitled "A Compendium for Fluid and Electrolyte Management with Ordinary and Extraordinary Laboratory Facilities." A 1946 graduate of the Indiana University School of Medicine, Indianapolis-Bloomington, Dr. Seidell will present the paper at the twenty-first annual meeting of the valley medical society at the Hotel Morrison, Chicago, September 26-28. He will receive a gold medal, a certificate and a cash award.

## COOK

**Leonard Jourdonais Named Chief of Medical Department.**—Dr. Leonard F. Jourdonais, Evanston, was recently named chief of the department of medicine of Evanston Hospital, effective September 1. He succeeds Dr. Lowell D. Snorf, Wilmette, who has become chief emeritus. Dr. Jourdonais, assistant professor of medicine at Northwestern University Medical School, has been a member of the Evanston Hospital staff since he graduated at Northwestern in 1933, with the exception of two years spent in residency at the New York Postgraduate Hospital.

**Personal.**—During a recent tour of Europe, Dr. Hans von Leden presented a series of lectures on largyngeal physiology at the Universities of Groeningen in Holland, Hamburg in Germany, Copenhagen in Denmark, Vienna in Austria, Zurich in Switzerland and London, England. On June 8 he addressed the Danish Otolaryngological Society at Copenhagen on radical surgery for cancer of the head and neck; and presented newer observations on the function of the normal larynx. On June 12, Dr. von Leden covered the same topics at a special meeting of the Austrian Otolaryngological Society. The physician is the medical director of the Voice Clinic and Voice Research Laboratory at Northwestern University Medical School.—Dr. Paul C. Bucy, neurologist, has been appointed honorary professor at the University of Minas Gerais in Belo Horizonte, Brazil, where, in 1954, he served as a visiting professor for two months.

**Faculty Changes.**—Dr. John L. Nickerson has been appointed chairman of the department and professor of physiology and pharmacology at The Chicago Medical School. He comes to the school from Columbia University College of Physicians and Surgeons where he was professor of physiology. Dr. Chi Kong Liu has been promoted to clinical associate in medicine at the school.

**Ground Broken for Memorial Pavilion.**—Ground breaking ceremonies were held, July 24, for the new $810,000 Berman and Hannah Friend Memorial Pavilion at Michael Reese Hospital. According to the Chicago Tribune, the pavilion is being constructed with a fund, now amounting to two million dollars, which was willed by Dr. Emanuel Friend, who died in 1938, for construction and maintenance of the pavilion as a memorial to his parents. The

building will contain thirty-six patient beds.

**Work Started on Passavant Addition.**—Ground was broken, August 2, for a $3,800,000 nine story addition to Passavant Hospital. Construction is expected to take twenty-two months. More than $3,400,000 has been raised by the hospital. The expansion will provide space for additional bed capacity, a metabolic unit, a cardiac center, an auditorium, a conference-classroom, a postoperative recovery room, a new surgical section, an improved obstetrical section, an enlarged x-ray department and a clinical laboratory, seminar rooms, an expanded laundry, and many other new units. An audiovisual nurses call system and a pneumatic tube system will increase efficiency of service to patients.

**Shriners' Hospital Receives $50,000.**—The Shriners' Hospital for Crippled Children was recently presented with a check for $50,000, the proceeds from this year's Shrine circus.

**Chicago Participants in Anesthesia Meeting.**—The Annual Meeting of The American Society of Anesthesiologists will be held in Kansas City, October 8-12, 1956. Sessions will be held in the Municipal Auditorium. Chicago participants will be Drs. E. Trier Morch on "The Safety and Dangers of Respiratory Alkalosis"; Bernard V. Wetchler and William O. McQuiston, "Anesthetic Management of Infants and Children with Double Aortic Arch"; Max S. Sadove, Reuben C. Balagot and Harry Linde, "Effect of Fluoromar Upon Certain Organ Functions".

**Paul Holinger Directs Course.**—A course in laryngology and bronchoesophagology will be given at the University of Illinois College of Medicine, November 5-17, 1956, under the direction of Dr. Paul H. Holinger. Registration may be made through the department of otolaryngology at the college of medicine, 1853 West Polk Street, Chicago 12, Illinois.

**Postgraduate Courses.**—The Chicago Medical Society is sponsoring two postgraduate courses at the Knickerbocker Hotel. The first, October 29-November 2, 1956, will be on "Modern Therapeutics" and cover the following: Hypertension, Anxiety, Choice of Surgical Operations, Antibiotics, Anti Cancer and Anti Leukemic Drugs, Dermatology, Steroids, Recent Advances in the Treatment of Selected Disorders of Metabolism and Organ Disease, and Physical Medicine. The second course, November 5-9, will be on "Practical Aspects of Endocrinology and Metabolism." This session has been broken down into the following: Diabetes, Hormones and the Male—Adrenals, Etc., Hormones and the Female, Thyroid, and Metabolism. The registration fee for each course is $75.00. Drs. John F. Sheehan and Harry F. Dowling are Co-Chairmen of the Committee on Postgraduate Medical Education of the Chicago Medical Society; other members are Drs. Wright R. Adams, S. Howard Armstrong, Jr., John O'Donoghue, Sr., Herbert Rattner, Theodore Van Dellen, Augusta Webster and Leo Zimmerman. Additional information on the courses may be obtained from the Chicago Medical Society, 86 East Randolph Street, Chicago 1; telephone: Central 6-3026.

**Capps Prize Open for Chicago Medical Graduates.**—The Joseph A. Capps Prize of $300 is being offered by the Institute of Medicine of Chicago for the most meritorious investigation in medicine or in the specialties of medicine. The investigation may be also in the fundamental sciences, provided the work has a definite bearing on some medical problem. Competition for 1956 is open to graduates of Chicago medical schools who completed their internship or one year of laboratory work within a period of five years prior to Jan. 1, 1956, excluding their terms of service in the Armed Forces. Manuscripts must be submitted to the Secretary of the Institute of Medicine of Chicago, 86 East Randolph Street, Chicago 1, not later than Dec. 31, 1956. The manuscript of the prize paper, as submitted, is to become the property of the Institute of Medicine of Chicago. The prize winner may be invited by the Board of Governors of the Institute to present his paper at a meeting of the institute. If no paper submitted is deemed worthy of the prize, the award may be withheld at the discretion of the Board of Governors.

**Medicine and Social Research.**—Two public lectures were given in August under the auspices of the University of Chicago in conjunction with the Social Science Research Council Summer Research Training Institute in Survey Methods in Research on Health Problems conducted by the National Opinion Research Center. The first, August 9, was given by Jack Ewalt, Massachusetts Commissioner of Mental Health, on "Evaluating Mental Health Programs", and the second, August 17, by Wilson G. Smillie, executive director, State Charities Aid Association of New York, on "Future of Preventive Medicine in the United States."

**John Cooper Named an Assistant Dean at Northwestern.**—Dr. John A. D. Cooper has been appointed an assistant dean of Northwestern University Medical School. An associate professor of biochemistry, Dr. Cooper received his Ph.D. and M.D. degrees at Northwestern. He has been a member of the medical school faculty since 1943. Dr. Cooper is presently in Brazil to direct a course on radioisotope technics in biology and medicine. He will also make a three month lecture tour of South American universities and scientific societies. The journey is under the auspices of the U. S. State Department in connection with America's "atoms for peace" program.

**Study Program to Combine Premedical and Medical Education.**—The John and Mary Markle Foundation has given $75,000 to Northwestern University Medical School to finance a study of a program to combine premedical and medical education. Further support will come from a portion of a recent $300,000 grant from the Commonwealth Fund. According to Dr. Richard H. Young, dean of the medical school, the new teaching plan would

be designed to provide one continuous program of education in basic sciences, humanities and medicine. Instead of two separate, sharply divided programs of undergraduate premedical study followed by professional study of medicine in medical school, students would begin the new course on graduation from high school and finish with the degree of doctor of medicine.

The study will be conducted jointly by faculty members of the medical school, the college of liberal arts and the graduate school. Under the plan being studied, a student would enter a combined premedical and medical course on graduation from high school. The course would last seven or eight years and would present a unified progression of study in the arts and physical, biological and medical sciences from general concepts to the specialized aspects peculiar to the medical profession.

There would be no sharp break between premedical and medical education; education in all fields would continue throughout the program, during which time the students would spend about one-third of their time in each of the three general areas of arts, science and clinical medicine. At the beginning the student would be exposed to courses whose mastery is more dependent on memory. Material which requires maturity, integration and understanding would come during later years.

Ideas and methods of premedical and medical teaching now being used and the implications of recent advances in medicine in treating disease will be examined in launching the study. Other steps will be to study the facilities and personnel that would be needed, and to collect and analyze opinions, ideas and suggestions of students, doctors and faculty members throughout the country.

Committee members in charge of the project are: Moody E. Prior, dean of the graduate school, chairman; J. Lyndon Shanley, associate dean of the college of liberal arts; Irving M. Klotz, professor of chemistry in the liberal arts college; Dr. John A. D. Cooper, associate professor of biochemistry and Markle scholar in the medical school, and Dr. George Yacorzynski, associate professor of neurology and psychiatry in the medical school.

**Marc Hollender Goes to Syracuse.**—Dr. Marc H. Hollender, assistant professor of psychiatry at the University of Illinois College of Medicine, has accepted an appointment as professor and chairman of the department of psychiatry, State University of New York College of Medicine, Syracuse, New York. Another Chicago physician, Thomas S. Szasz, member of the staff of the Institute of Psychoanalysis, will also go to Syracuse as professor of psychiatry.

## DU PAGE

**New Health Officer.**—Dr. Charles A. Lang became health officer for DuPage County August 1. Prior to this he served as health officer in the west district office at Maywood of the Cook County Health Department where he also served a year's residency experience, making him the first physician to occupy one of the medical public health residencies in Illinois, according to the Illinois Health Messenger. A graduate of Northwestern University Medical School, Dr. Lang also holds the Master of Public Health degree from the University of Michigan.

## WARREN

**Past President Norbury Gives Inspiring Talk.**—F. Garm Norbury, Jacksonville, immediate Past President of the Illinois State Medical Society, addressed the Rotary Club of Monmouth, July 23, on "Mental Health." In reporting the event, Dr. Charles P. Blair, Monmouth, and Councilor of the Fourth District, said this was a clear-cut, concise and inspiring talk. Members of the Warren County Medical Society were guests of the Rotary Club.

## GENERAL

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**George M. Cummins, Jr.,** associate in medicine, Northwestern University Medical School, U. S. Navy Reserve Research Co. 9-1, at Navy Pier, October 9, 1956, on "Geriatrics."

**Sanford A. Franzblau,** clinical assistant professor of medicine, University of Illinois College of Medicine, Unity Nurses Club in Oak Park, October 24, 1956, on "Cerebral Thrombosis and Other Conditions Involving Blood Clots."

**George H. Klumpner,** member of the staff of the Institute for Juvenile Research, Village Woman's Club in Clarendon Hills, October 15, on "Psychiatry and Mental Health."

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**William H. Langewisch,** member of the staff of Rockford Memorial Hospital, Rock Island County Medical Society, September 11, on Pediatric Problems of Interest to the General Practitioner.

**Charles D. Branch,** Peoria, assistant clinical professor of surgery, University of Illinois College of Medicine, Henry County Medical Society in Kewanee, September 12, on Indication for Surgical Treatment in Gastric and Duodenal Ulcers.

**Benjamin Boshes,** professor of neurology and psychiatry, Northwestern University Medical School, Champaign County Medical Society, October 11, in Champaign, on "Use of the Newer Tranquilizing Agents.

**A. Beaumont Johnson,** assistant attending neurosurgeon, Presbyterian Hospital, Iroquois County Medical Society in Watseka, October 16, on Organic Psychosis.

**John A. Mart,** associate in medicine, Northwestern University Medical School, Kankakee County Medical Society in Kankakee, October 16, on Recent Advances in Heart Disease.

**J. Keller Mack,** member of the staffs of St. John's and Memorial Hospitals, Springfield, Montgomery and Macoupin County Medical Societies in Litchfield, October 17, A Commonly Missed Chest Lesion in Children.

## DEATHS

**Benjamin F. Andrews***, retired, Evanston, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1894, died June 13, aged 92.

**John W. Beare***, Chester, who graduated at the Hahnemann Medical College and Hospital in 1907, died recently, aged 75.

**Martha Kirstine J. B. Blanchard,** Mount Olive, who graduated at Jenner Medical College in 1910, died May 14, aged 77, of fracture of the lower end of the right femur and shock.

**Raymond Samuel Brown***, Morris, who graduated at Rush Medical College in 1905, died in Newport Beach, California, April 18, aged 77. He formerly practiced in Joliet where he was a member of the staffs of St. Joseph's and Silver Cross Hospitals.

**Charles A. Burkholder***, Chicago, who graduated at Rush Medical College in 1912, died July 27, aged 70. He was a member of the staff of Grant Hospital and a past president of the Central Lions Club of Chicago.

**James C. Clarke***, LaGrange, who graduated at Rush Medical College in 1913, died July 12, aged 70. He had practiced medicine in LaGrange for 40 years.

**Charles G. Darling,** Evanston, who graduated at Northwestern University Medical School in 1903, died August 8, aged 79. He was professor emeritus of ophthalmology at the University of Illinois College of Medicine and past president and secretary of the Chicago Ophthalmological Society.

**Philip Herman Dechow***, Kinderhook, who graduated at the Keokuk Medical College, College of Physicians and Surgeons, in 1906, died in Abingdon, April 2, aged 78.

**Douglas C. Hurley***, Elgin, who graduated at Northwestern University Medical School in 1925, died July 15, aged 57. He was past president of the Kane County Medical Society and a veteran of both World Wars.

**Konstantin V. Kirov,** Chicago, who graduated at Leopold Franzens Universität Medizinische Fakultät, Innsbruck, Germany, in 1947, died in July, aged 34.

**Myron E. Lollar***, Tuscola, who graduated at the University of Illinois College of Medicine in 1913, died April 4, aged 78, of pulmonary hemorrhage. He was representative in the Illinois General Assembly from the 51st district.

**Carl S. Montgomery***, Stockland, who graduated at Illinois Medical College in 1903, died April 26, aged 80.

**Benjamin D. Mosher,** Sandwich, who graduated at Keokuk Medical College, Iowa, in 1898, died May 14, aged 81. He had practiced medicine for 50 years.

**Henry Orson Munson***, Rushville, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1890, died July 14, aged 88. In 1955 he was named Illinois' "outstanding general practitioner for the year."

**Karl Benedict Riegger***, Freeport, who graduated at Loyola University School of Medicine in 1919, died March 20, aged 60, of acute coronary occlusion. He was a member of the staffs of the Deaconess and St. Francis Hospitals.

**Frederick Rose***, retired, Millstadt, who graduated at the St. Louis College of Physicians and Surgeons in 1892, died recently, aged 86.

**Jerome L. Rosengard***, formerly of Chicago and recently of Stockton, California, who graduated at the University of Illinois College of Medicine in 1926, died December 27, 1955, aged 56.

**George D. Runkle***, Stockton, who graduated at Northwestern University Medical School in 1903, died July 3, aged 77, of intestinal carcinoma.

**Karl Singer***, Chicago, who graduated at Medizinische Fakultät der Universität, Wien, in 1927, died July 12, aged 54. He had been head of the department of hematology at Michael Reese Hospital since 1947.

**Guy A. Sloan***, Bloomington, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1913, died April 24, aged 67.

**Julius L. Spivack***, Chicago, who graduated at Odessa Medical Institute, Russia, in 1914, died March 30, aged 67. He was clinical associate professor at the University of Illinois College of Medicine.

**Richard Perrie Still***, LaGrange Park, who graduated at the University of Illinois College of Medicine in 1950, died April 2, aged 33. He was a member of the staffs of the McNeal Memorial Hospital, Berwyn, and member and vice-president of the staff, Community Memorial Hospital in La Grange.

**Gerald A. Sullivan***, Dwight, who graduated at Marquette University School of Medicine, Milwaukee, in 1917, died recently, aged 64.

**John Thomas Sullivan,** Sr., retired, Chicago, who graduated at the Chicago College of Medicine and Surgery in 1914, died April 15, aged 77, of cerebral thrombosis.

**Alan F. Thometz***, Glenview, who graduated at Northwestern University Medical School in 1947, died August 4, aged 33. He was a member of the staff of Resurrection Hospital.

**Stanley R. Veselsky,** Chicago, who graduated at Dearborn Medical College, Chicago, in 1905, died December 12, 1955, aged 67, of arteriosclerotic heart disease.

**Earl V. Wilcox***, retired, Flanagan, who graduated at the Chicago College of Medicine and Surgery in 1914, died recently, aged 71.

**Edward C. Williams***, Downs, licensed in Illinois in 1899, died February 3, aged 81, of coronary artery disease. He was past-president of the McLean County Medical Society.

---

*Member, Illinois State Medical Society



*'Thorazine' relieved this patient's anxiety, tension and fear and made it possible for him to return to work.*

'THORAZINE' CASE REPORT

*patient:* Anxiety, tension, and a fear of going out alone made it impossible for this 36-year-old man to work. After other treatments had failed he was given 'Thorazine'.

*response:* "On 'Thorazine' medication, 100 mg. orally, daily, his anxiety and apprehension disappeared immediately. The patient was able to go out alone and to work once again. His mood was actually gay and his co-workers were surprised at this change. He was now free from care whereas before he had been distressed by the slightest difficulty."

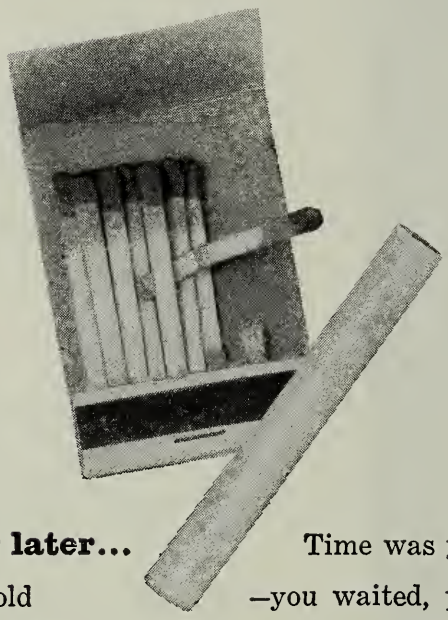
This case report is from the files of a general practitioner.

# THORAZINE*

Available in ampuls, tablets and syrup (as the hydrochloride), and in suppositories (as the base).

*Smith, Kline & French Laboratories, Philadelphia*

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S.K.F.



**save the cigarette for later...** Time was you had to wait for a local anesthetic to take hold —you waited, patient waited, nurse waited. **Now, rapid anesthesia....** Blockain* works so fast that clinicians had to describe it as "immediate" and "almost instantaneous." It's practically an understatement to call its action "rapid." **Longer anesthetic duration....** Besides being able to go to work sooner, you can work at an easier pace. Blockain lasts long enough so you can proceed from incision to closure on one injection. You finish up with a neat suture line undistorted by repeated instillations. The patient leaves uncomplaining and comfortable. ☞ *A busy clinician's experience with Blockain in fourteen cases of Colles' fracture:* A single 2-5 cc. injection of Blockain into the hematoma produced anesthesia in an average of 3 minutes 15 seconds. The average duration of these operations, closed reductions, was 25 minutes. Anesthesia persisted beyond the time required for reduction permitting splints to be applied, postreduction X-rays to be taken and the patients sent home feeling comfortable. **BLOCKAIN,** 30 cc., 0.5% (5 mg/cc.). Your office-ideal local anesthetic. For additional information write GEORGE A. **Breon** & COMPANY, 1450 Broadway, New York 18, N. Y.

*BLOCKAIN® BRAND OF PROPOXYCAINE HYDROCHLORIDE BREON.

# Meat...

## *and Its Place in the Diet in Congestive Cardiac Failure*

Meat has an appropriate place in the moderate-protein, low-sodium, acid-ash diet advocated in the dietary management of patients with congestive cardiac failure.[1] When extreme sodium restriction is necessary, the meat allowance is regulated accordingly.

Lean meat allows maintenance of a positive nitrogen balance without excessive protein intake, because its amino acids match the quantity and proportions needed for tissue synthesis and repair.[2,3] In the fresh state as purchased it supplies only small amounts of sodium ranging from approximately 50 to 100 mg. per 100 grams. Due to its acid-ash composition (equivalent to 4 to 38 ml. of normal acid per 100 grams of meat) it may facilitate diuresis.[1]

In addition to these important features, meat contributes valuable nutritional factors by virtue of its generous supply of high quality protein, B vitamins, and essential minerals—iron, phosphorus, potassium, and magnesium.

Easy digestibility, a prime requisite of foods eaten by the patient with congestive cardiac failure, is another outstanding quality of meat.

---


1. Odel, H. M.: Nutrition in Cardiovascular Disease, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Dietotherapy, Philadelphia, Lea & Febiger, 1955, p. 709.
2. Berg, C. P.: Utilization of Protein, J. Agr. & Food Chem. *3*:575 (July) 1955.
3. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, Williams & Wilkins, 1955, p. 638.


The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

**American Meat Institute**
**Main Office, Chicago...Members Throughout the United States**

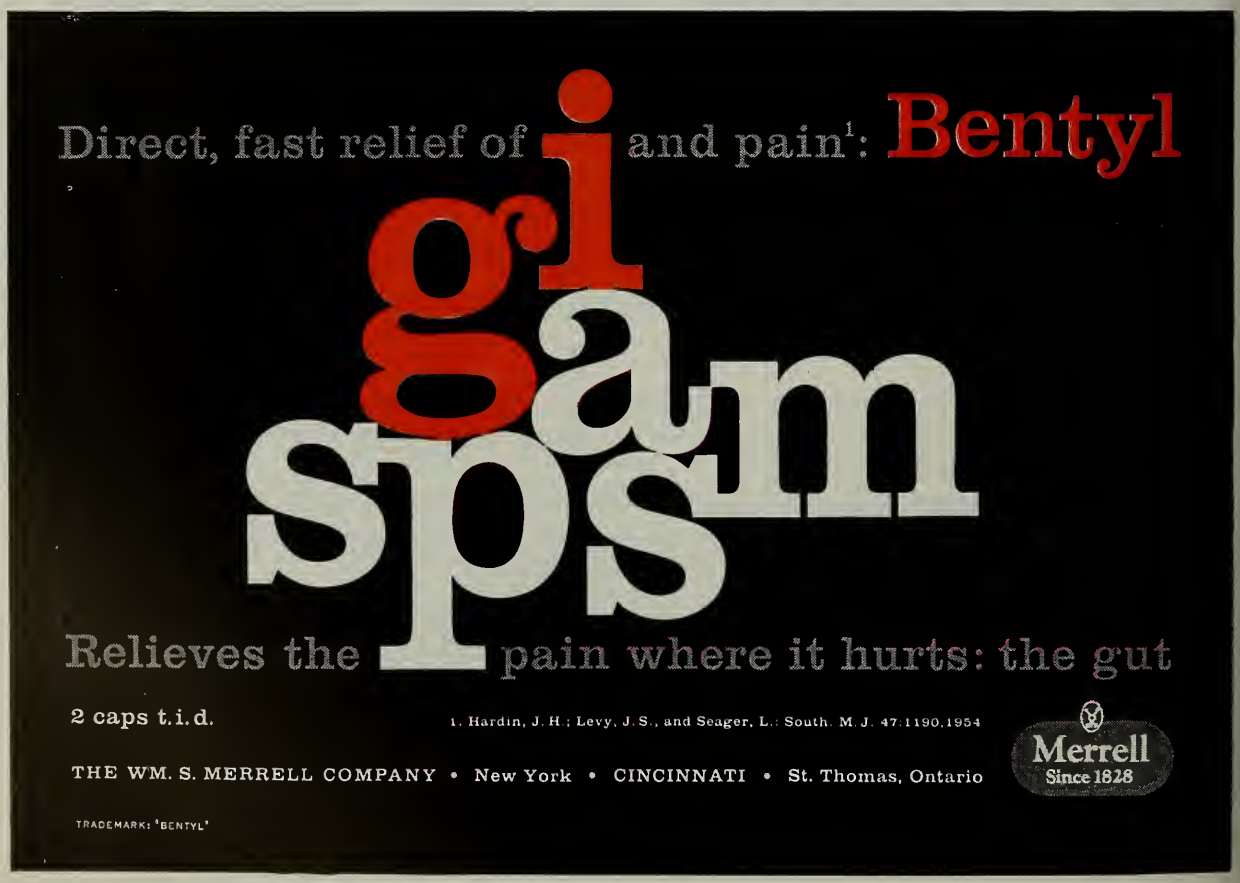
## Steroids and TBC

Reports published when cortisone and ACTH were first being used on a large scale clearly pointed out that tuberculosis can follow therapy with these drugs. It also was noted that tuberculous patients responded to the steroids with defervescence, increased strength, improved appetite, weight gain, and a subjective feeling of well being. At the same time, however, most showed no improvement or progression of lesions on x-ray study, and when the drugs were stopped, symptoms returned. In 1952 the Committee on Therapy of the American Trudeau Society prepared a statement in which the following conclusions were reached: Cortisone and ACTH therapy may reduce signs and symptoms of tuberculous disease even when the net effect of such treatment is harmful; this therapy may cause exacerbations of active or apparently inactive tuberculosis; and cortisone and ACTH tend to cause poor localization of tuberculous disease, and to facilitate widespread dissemination. As a result of the evidence then available, the Committee made the following recommendations: The presence of old, apparently inactive tuberculosis should be carefully evaluated for activity before hormone therapy is started, and frequent follow-up x-ray examinations and sputum studies should be made after such treatment is instituted; and, even in the absence of known tuberculous infection, x-ray examination of the chest before, during, and after hormone therapy is wise. Although the entire problem deserves reconsideration in the light of more recent studies, it seems prudent to follow the recommendations made above when one is planning to initiate therapy with ACTH or one of the adrenal steroids.*Irvin M. Golding, M.D. et al. Adrenocortical Steroids and Tuberculosis. New England J. Med. May* 31, 1956.

‹ ›

The average man takes life as a trouble. He is in a chronic state of irritation at the whole performance. He does not learn to differentiate between troubles and difficulties until some real trouble bowls him over. He fusses about pinpricks until a mule kicks him. Then he learns the difference.

— Herbert N. Casson



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Meti-steroid potency and safety

available for

topical skin therapy

**new**

# Meti-Derm*

## Cream 0.5%

with METICORTELONE, original brand of prednisolone

- more active than topical hydrocortisone, milligram for milligram
- no edema and sodium retention reported upon topical administration
- provides topical METICORTELONE in the free alcohol form. For effective relief of allergic (atopic) dermatoses, poison ivy dermatitis and other contact dermatoses, nonspecific anogenital pruritus.

**formula:** Each gram of METI-DERM Cream contains 5 mg. of prednisolone, free alcohol, in a water-washable base.

*also* for allergic, inflammatory dermatoses, minor secondary infections

**Meti-Derm** Ointment with Neomycin

**formula:** Each gram contains 5 mg. prednisolone and 5 mg. neomycin sulfate (equivalent to 3.5 mg. neomycin base) in a white petrolatum base.

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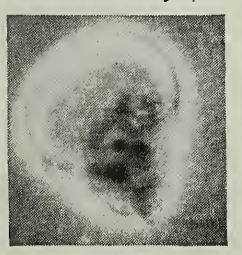


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TRICHOMONADS IN 15 SECONDS

WITH the Davis technique, both VAGISEC® liquid and jelly, flare-ups of vaginal trichomoniasis rarely occur. VAGISEC liquid actually *explodes* trichomonads within 15 seconds after douche contact.[1] Better than 90 per cent apparent cures follow use of this new trichomonacide developed as "Carlendacide," by Dr. Carl Henry Davis, noted gynecologist.[2]



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EXPLODES

*No trichomonad escapes* — Three chemicals in VAGISEC liquid combine in balanced blend to weaken the cell membrane, to remove waxes and lipids, and to denature the protein. With its cell wall destroyed, the trichomonad imbibes water, swells and explodes.

*The Davis technique*† — The physician uses VAGISEC liquid as a vaginal scrub at the office. He prescribes VAGISEC liquid and jelly for concomitant use at home.

*Infected husbands re-infect wives*[2] — Use of a condom breaks the infection cycle.[2] A prescription assures the protection afforded by Schmid quality condoms — RAMSES,® the finest possible rubber prophylactic; or XXXX (FOUREX)® skins of natural animal membranes, pre-moistened.

*References:* 1. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955.

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## Washington confidential

In the 25 years that soon will have elapsed since regional ileitis made its debut on the medical scene, progress has been made in establishing its physical boundaries and clinical features and in evaluating the respective roles and limitations of medical and surgical therapy. Pessimism and disillusionment about the effectiveness of any regimen in providing more palliation and control of symptoms and complications must be tempered by the realization of its relatively recent status. This question may not be fully resolved until therapy follows advances in etiology. Experimental efforts thus far have indicated various approaches along the pathway leading to granulomatous disease of the bowel. Though this is a clinical and apparently pathological entity, the primary etiologic factors may be heterogeneous. Certainly, no single cause has been described that can be considered responsible in all cases. As with many conditions of unknown etiology, therapy remains conservative and supportive, surgical intervention being limited to various complications and progressive intractability. The relative merits of any objections to the several accepted methods of surgical therapy are noted briefly. They all suffer from the disappointing sequel of recurrence or persistence of the disease. The more favorable results after surgery for the fixed, stenotic lesion are in contrast to those obtained in the nonobstructive, nonperforating, progressively ulcerating phase. *Louis Zetzel, M.D. Regional Enteritis. New England J. Med. May* 31, 1956.

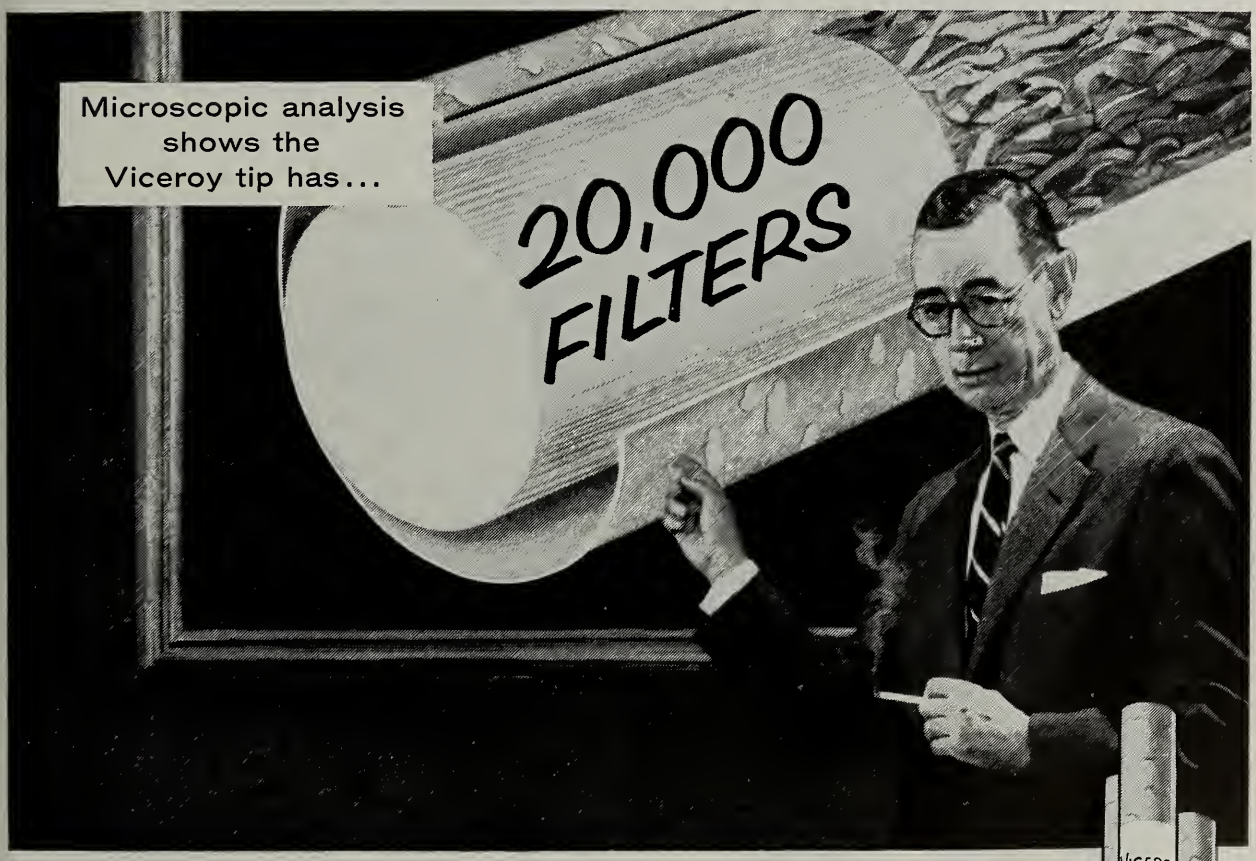
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If war should sweep our commerce from the seas, another generation will restore it. If war exhausts our treasury, future industry will replenish it. If war desiccate and lay waste our fields, under new cultivation they will grow green again and ripen to future harvest. If the walls of yonder Capitol should fall and its decorations be covered by the dust of battle, all these can be rebuilt. But who shall reconstruct the fabric of a demolished government; who shall dwell in the well proportioned columns of constitutional liberty; who shall frame together the skillful architecture which unites sovereignty with state's rights, individual security with prosperity?

— Daniel Webster

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# VICEROY

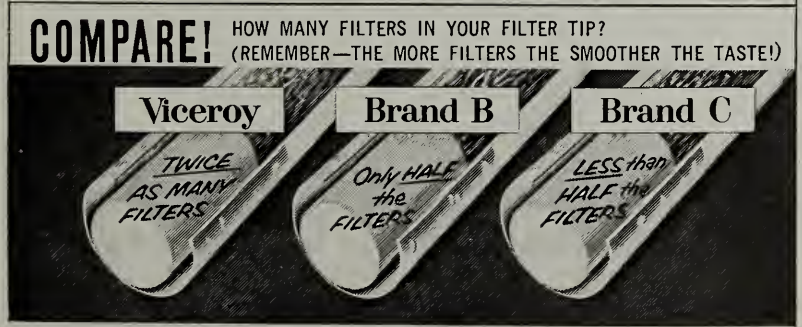



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## BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

DIAGNOSIS AND TREATMENT OF PERIPHERAL VASCULAR DISORDERS: By David I. Abramson, M.D., F.A.C.P., Professor and Head of the Department of Physical Medicine and Rehabilitation, and Professor of Medicine, University of Illinois, College of Medicine. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 49 East 33rd Street, New York 16, New York. $13.50.

ESSENTIAL UROLOGY: By Fletcher H. Colby, M.D., Consultant, Massachusetts General Hospital. Third edition. The Williams & Wilkins Company, Baltimore. $8.00.

OF WATER, SALT AND LIFE—an atlas of fluid and electrolyte balance in health and disease. Lakeside Laboratories, Inc., Milwaukee. 72 pages, 31 plates. $7.50.

J. A. M. A., QUERIES AND MINOR NOTES. Published for the American Medical Association by The C. V. Mosby Company, Saint Louis. $5.50.

CLINICAL UROLOGY FOR GENERAL PRACTICE: By Justin J. Cordonnier, M.D., F.A.C.S., Professor of Urology, Washington University School of Medicine, St. Louis. Illustrated. The C. V. Mosby Company, St. Louis. $6.75.

CLINICAL UROLOGY. By Oswald Swinnery Lowsley, A.B., M.D., F.A.C.S., F.I.C.S., Diplomate of American Board of Urology, and Thomas Joseph Kirwin, M.A., M.S., M.D., F.A.C.S., F.I.C.S., Diplomate of American Board of Urology. Third Edition. Two volume set, $32.50.

TREATMENT OF THE CHILD IN EMOTIONAL CONFLICT: by Hyman S. Lippman, M. D., University of Minnesota, Minneapolis, Minn. McGraw-Hill Book Company, New York, 1956. Priced $6.00.

TREATMENT OF HEART DISEASE: A Clinical Physiologic Approach. By Harry Gross, M. D., F. A. C. P., and Abraham Jezer, M. D. With 91 illustrations. W. B. Saunders Company, Philadelphia, 1956. Price $13.00.

THE RECOVERY ROOM: Immediate Postoperative Management. By Max S. Sadove, M. D. and James H. Cross, M. D., with contributions by 24 authorities. Illustrated. W. B. Saunders Company. Philadelphia, 1956. Price $12.00.

‹ ›

The prevailing attitude at the present time is that the diet of the tuberculosis patient should very nearly approximate that of the person in good health, with somewhat more emphasis on protein and vitamin content. Seymour M. Farber, M.D., Roger H. L. Wilson, M.D., and Nancy L. Hooper, B. S., J. Lancet, April, 1956.





**Trasentine®-Phenobarbital**

*integrated relief . . .*
mild sedation
visceral spasmolysis
mucosal analgesia

**TABLETS** *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

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*Made from Grade A Milk (U.S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with animal and vegetable fats and by the addition of synthetic vitamins. No carbohydrate has been added.

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assures full potency

Separate packaging of dry vitamins and diluent (mixed immediately before injection) assures the patient a more effective dose. May also be added to standard IV solutions.

Dosage: 2 cc. daily.

Each 2 cc. dose contains:

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| Thiamine HCl ($B_1$) | 10 mg. |
| Riboflavin ($B_2$) | 10 mg. |
| Niacinamide | 50 mg. |
| Pyridoxine HCl ($B_6$) | 5 mg. |
| Sodium Pantothenate | 10 mg. |
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| Vitamin $B_{12}$ | 15 mcgm. |
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## Tranquilizing trends

It is too early to fully evaluate our data on the movement of our patients but we have noted a steady, moderate decline in our average daily population during the past four months and an increase in the number of patients able to stay out of the mental hospital on visit status. If this trend is continued it may represent a most significant alteration in mental hospital operations. We are beginning to consider possible needs for modification of our staffing and building patterns. Perhaps we will need more therapists of all types and fewer attendants who function largely as guards; more activity space and less space for electric shock therapy; fewer wards with steel screens or iron bars; more social service workers and rehabilitation and vocational counselors. Thus far the application and use of these drugs has been largely empirical. However, it may be that the breakthrough in psychiatry—if I may use that intriguing word with uncertain meaning—is at hand. *Jay L. Hoffman, M.D. General Summary (Symposium on Chlorpromazine and Reserpine). Med. Ann. District of Columbia, May* 1956.

‹ ›

## The placenta in ectopic pregnancy

In most extra-uterine pregnancies the abnormal placental site is in the pelvis. Cornell and Lash (1933) found records of 236 pregnancies involving placental attachments to 641 sites, the great majority being in the pelvis. In eight cases, one site of attachment was the liver but note was not made whether this was ever the sole area. Echols (1934) and Barrett (1952) mentioned patients in whom the placental site involved several organs, one of which was the liver. Billington and Goodchild (1948), Serebriakova and Kanshin (1952), and Van de Loo (1953) described placental sites solely in the liver. *A. H. G. Murley, M.B. Lancet, June* 23, 1956.

‹ ›

There is a general reluctance on the part of elderly men to submit to medical examination, especially if it means going to a clinic or hospital. They will more readily call in the doctor or go to the general practitioner's surgery; old people do not look with much favor on a visit to the mass radiography service. F. R. G. Heaf, M.D., J. Royal Inst. Pub. Health and Hygiene, Nov., 1955.



*little*

# How to win friends ...




The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

*We will be pleased to send samples on request.*

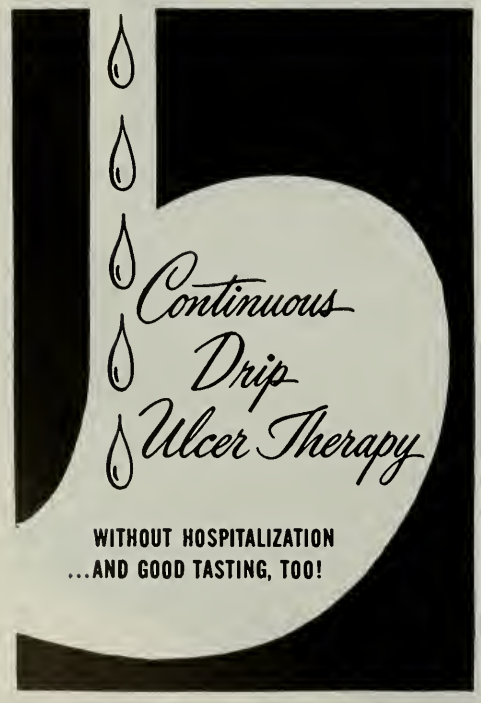
**THE BAYER COMPANY DIVISION** of Sterling Drug Inc. 1450 Broadway, New York 18, N. Y.

## The preventive of shoulder-hand syndrome

As a preventive measure, Leichtentritt routinely prohibited inactivity of both shoulders and hands in 93 patients with myocardial infarction treated between 1949 and 1954. In them, there were no instances of the shoulder-hand syndrome. This was in contrast to a group of 71 patients with myocardial infarction treated in the preceding five year period to whom the exercises had not been given; of these, 13 (18 per cent) had the syndrome. Leichtentritt's method was as follows: At the time of the physician's daily visit, the patient's arms were raised slowly and gently, one at a time, straight up and parallel to the body, as high above the head as his condition and tolerance allowed. The procedure was repeated by a nurse one other time during the day, even while he was in an oxygen tent. No difficulty was encountered in its performance and there were no untoward effects on the heart. About 14 days after the onset of myocardial infarction, the patient was instructed to perform these movements of the arm two to three times daily. This daily exercise was continued indefinitely. The same procedure was prescribed for patients having frequent and severe attacks of angina pectoris. It was equally successful in preventing the syndrome in them. Conventional therapy for myocardial infarction should be continued during treatment for the shoulder-hand syndrome, or as long as there is evidence that it is needed. The syndrome may not be completely relieved until the infarct is healed. The severity of the symptoms of the syndrome and of the myocardial infarct are not always parallel, however. *The Shoulder-Hand Syndrome. Heart Bull. May-June* 1956.

‹ ›

In the United States our principal problem from here on is that of dealing with the person who reacts to the tuberculin test. Evidence is pretty overwhelming that the great majority of new active cases of tuberculosis occur among those who have been reactors to tuberculin for some time and represent a breakdown into active disease of a smoldering infection of virulent tubercle bacilli. James E. Perkins, M.D., Managing Director, Bulletin, NTA, Jan., 1956.


HORLICKS CORPORATION
*Pharmaceutical Division*
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# Nulacin

A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. *22*:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.



# VI-DAYLIN®

**Each 5-cc. teaspoonful of VI-DAYLIN contains:**

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| Vitamin A | 3000 U.S.P. units (0.9 mg.) |
| Vitamin D | 800 U.S.P. units (20 mcg.) |
| Thiamine Hydrochloride | 1.5 mg. |
| Riboflavin | 1.2 mg. |
| Pyridoxine Hydrochloride | 1.0 mg. |
| Ascorbic Acid | 40 mg. |
| Vitamin $B_{12}$ | 3 mcg. |
| Nicotinamide | 10 mg. |

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HORMOGEN R-A
(Rapid Action)




**HORMOGEN R-A** (Rapid Action) combines the fast action of water-soluble Potassium Estrone Sulfate with the prolonged action of water-insoluble Estrone. Patient is gratified by the immediate relief and you have immediate insight into the effectiveness of the medication. Because of prolonged action, injections can be spaced 3 to 7 days apart.

HORMOGEN R-A: Aqueous suspension in 10 cc. multiple dose vial: each cc. represents Estrone U.S.P. 2 mgs., Potassium Estrone Sulfate 1 mg.

INDICATIONS: Menopause syndrome, for control of uterine bleeding of endocrine origin, senile vaginitis, kraurosis vulvae and puritis vulvae.

DOSAGE: ½ cc. to 1 cc. once or twice a week.

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## Stripping veins

Today, undoubtedly, the greatest number of patients with varicosities undergo surgery for cosmetic reasons since the glamorous leg is the desire of all men and women. Therefore, it is conceivable that the goal in the surgical treatment of this condition is not only obliteration of the involved varicosities but also minimal scarring. Described in the literature are many variations of strippers and techniques as aids in achieving the goal. We have had extremely successful results in a limited number of cases by using the method of high saphenofemoral ligation, and stripping of the varicose veins with a double Emerson coupling. We have found the passage from below upward successful in the majority of cases. The saphenous vein is marked previously near the medial malleolus and, with a small incision, dissection of the large vein is performed easily. Passage of the bougie starting at this end is met with little resistance as the flexible strippper traverses the extremity. *Ray S. Greco, M.D. and R. E. Flood, M.D. Stripping of Varicose Veins with a Double Stripper. West Virginia M.J. June* 1956.

‹ ›

## Advancing technology

G. K. Chesterton, who died in 1936, wrote of the wide gap between the scientific mind and the consequences of the knowledge produced by scientific thought: "When a man splits a grain of sand," he said, " and the universe is turned upside down in consequence, it is difficult to realize that, to the man who did it, the splitting of the grain is the great affair, and capsizing of the cosmos quite a small one." *Mark D. Hollis. Dynamic Impact of Advancing Technology on Environment and Health. Pub. Health Rep. May* 1956.

‹ ›

The need for adequate sanatorium care and management of the tuberculous patient during the initial phase of his disease requires re-emphasis. The extent and variety of tuberculous disease, previous antimicrobial therapy, the desirability of oral or parenteral administration of drugs, and other practical and clinical considerations will undoubtedly influence the choice of chemotherapy for the individual patient. Abraham Falk, M.D., J. Lancet, April, 1956.

ıy fever and other difficult allergies...

# METICORTEN

(PREDNISONE)

for outstanding hormonal control
with minimal electrolyte disturbances

in hay fever and other respiratory allergies,
contact dermatitis and allergic eczemas,
drug and other allergic reactions,
allergic and inflammatory eye disorders




METICORTEN,* brand of prednisone.
1, 2.5 and 5 mg. tablets. *T.M. MC-J-3086

Schering

## Galactosemia

The cause of galactosemia, also known as galactose diabetes, an often fatal metabolic disease of children, has been discovered by scientists of the National Institute of Arthritis and Metabolic Diseases, Public Health Service. It was reported in official announcements on March 12, 1956. This disease ordinarily appears within a few days after birth. The infant suffering from galactosemia is unable to utilize or even tolerate milk in any form. Lactose, often called milk sugar, contains another sugar—galactose. This substance cannot be handled by the child's system if he has galactosemia. Drs. Herman M. Kalckar, Elizabeth P. Anderson, and Kurt J. Isselbacher, at the National Institutes of Health, discovered a hitherto unknown enzyme in normal red blood cells, which they call P-Gal transferase. This enzyme, they found, is necessary to complete conversion in the body of galactose into glucose, the common sugar of the blood. *Pub. Health Rep. May* 1956.

## Retirement

The physician has a responsibility to himself. If he lives long enough he is going to be a geriatrician by example or in practice. Has he provided well for his old age? Has he been prudent with his money? As a professional man, his income is likely to be exaggerated by the laity; he is expected to contribute to all worthy causes; and he can look forward to no outside contribution if he should retire. But need for current income and the habit of being of service to his fellow men make it improbable that he will retire. *Robert T. Monroe, M.D. The Geriatric Physician's Responsibility. New York J. Med. Apr.* 15, 1956.

‹ ›

Health is expensive, but disease is even more so. Those who have funds to invest in the welfare of the country of tomorrow could do no better than investing them in the welfare of the students of today. Dana L. Farnsworth, M.D., Bulletin, NTA, May, 1956.


*For the Aged and Senile Patient*




ORAL *Metrazol*

— to help the geriatric patient with early or advanced signs of mental confusion attain a more optimistic outlook on life, to be more cooperative and alert, often with improvement in appetite and sleep pattern.
Metrazol, a centrally acting stimulant, increases respiratory and circulatory efficiency without overexcitation or hypertensive effect.

Dose: 1½ to 3 grains, 1 or 2 teaspoonfuls Liquidum, or the tablets, every three or four hours.

Metrazol tablets, 1½ grs. (100 mg.) each. Metrazol Liquidum, a wine-like flavored 15 per cent alcoholic elixir containing 100 mg. Metrazol and 1 mg. thiamine HCl per teaspoonful.

Metrazol®, brand of pentylenetetrazol, a product of E. Bilhuber, Inc.

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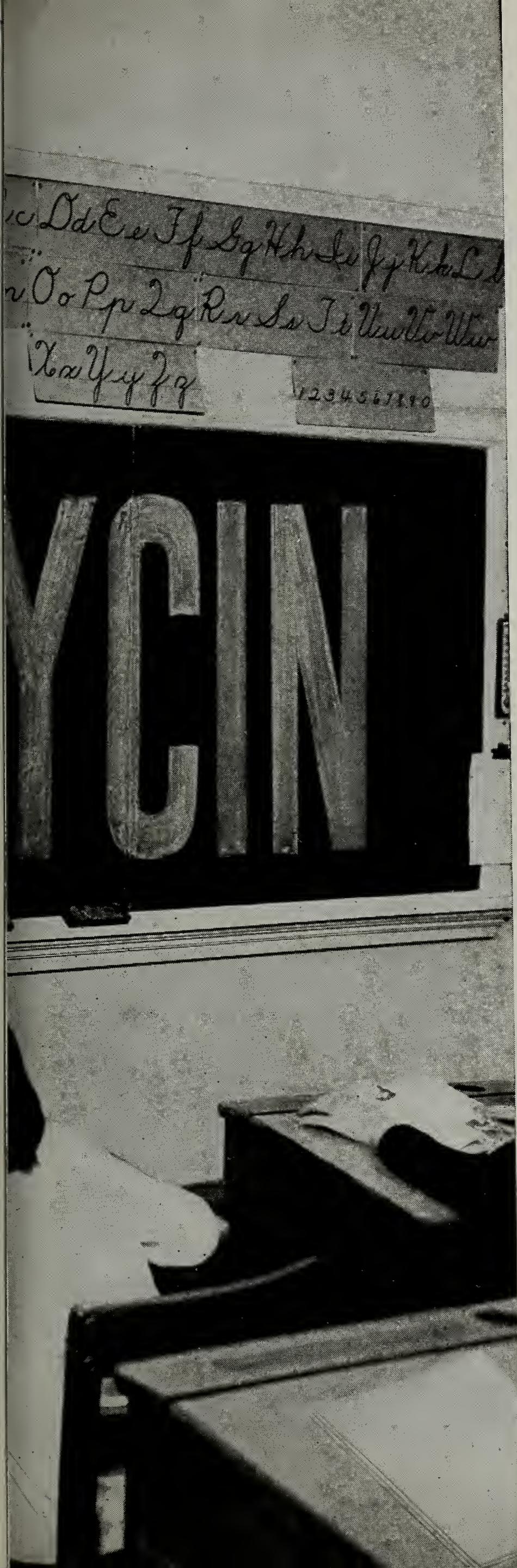
## The hard of hearing child

A further problem that influences the development of the child with hearing loss is the attitude of the parent toward the child and his problems.While many parents are able to give the child the love and understanding he needs, the discovery of a defect sometimes seems to bring out negative feelings on the parents' part. Sometimes guilty feelings at producing a child with such a problem cause a parent to reject the child overtly or to become oversolicitious and demand unreasonably perfect performance, only dimly masking the true feelings underneath — feelings of which the child is all too often aware. In such cases the child is the living example which continually reminds the parent of his child's problems and makes him struggle unconsciously with the feelings of rejection toward the child. In this situation, each parent has to work out his own adjustment to his child and his problem. Not infrequently, the father blames the mother and the mother blames herself, placing the child in the midst of a constant stream of tension flowing between parents and between the parents and the child. Then, too, there are parents who compound the problem by clinging to the hope that hearing can be restored by medical or magical means. They plead for fenestration operations, spines are adjusted, hearing aids purchased without discrimination, airplane rides are suggested, adenoids are removed - all usually with little or no effect upon hearing. Slightly more realistic parents may accept the handicap but expect use of a hearing aid to endow the child with perfect hearing, normal speech and language, and no observable handicap. The truth is that in most cases where there is severe loss of hearing, there will always be a handicap. The well adjusted parent aims to help this child become a competent, happy, well adjusted, hearing-impaired person who communicates with relative ease and is comfortable in the hearing world, rather than a poor imitation of a hearing person, always laboring to conceal his handicap and never succeeding. *Richard H. Wehr, M. D. and Marshall A. Becker. Loss of Hearing: the Patient and his Problem. Ohio M. J. July* 1956.

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Forty is the old age of youth; fifty is the youth of old age.

—Victor Hugo



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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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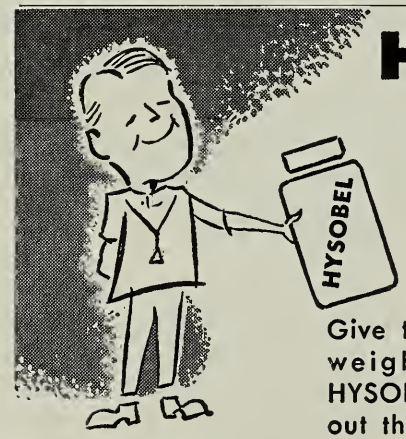
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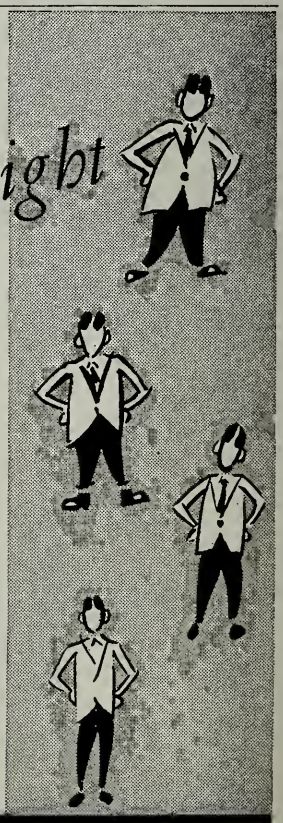
## A new type of eternal triangle

The essential cause for the lowered prestige of the family doctor lies, I believe, in the National Health Service. First, the Act altered the relationship between the (British) doctor and the patient, by introducing the State as a third party. This new type of eternal triangle is fraught with as many dangers as the more familar type and has tended to make the relationship between the contracting parties less personal and more liable to lack that esteem and mutual trust which are essential if confidence is to be engendered. I know that in a State provided scheme such intrusion is unavoidable. Secondly, the manner in which the National Health Service was introduced was unfortunate. It was heralded as a free service in such a way as to lead to irresponsible demands, not only for time-absorbing service but for supplies which many expected to be forthcoming, not according to need as judged by the doctor, but as something which the patients' weekly contribution entitled them to receive on demand. The development of this "entitlement" complex led to full surgeries and high prescription rates. This made it more difficult to give that extra time which modern medical science requires. The erroneous belief of many patients that their insurance contributions pay for the whole of the benefits of the Health Service has altered their attitude to the whole profession and made them more prone to be litigious although of course the free legal aid scheme has greatly encouraged this. Thirdly, what was worse, the specialist services were heralded as something new and superior, and available to every citizen for the first time; by comparison, the family-doctor service was thus presented as a second rate affair with limited capacities. Denial to the family doctor of diagnostic facilities in the X-ray department and the laboratory, except through consultant and specialist, exaggerated the apparent incompetence of the general practitioner, while the denial of his right of access to hospital beds even for midwifery, completed the ignominy and altogether undermined confidence in him. *Alexander Hall, M.D. The State of General Practice Today. Brit. M. J. July* 14, 1956.


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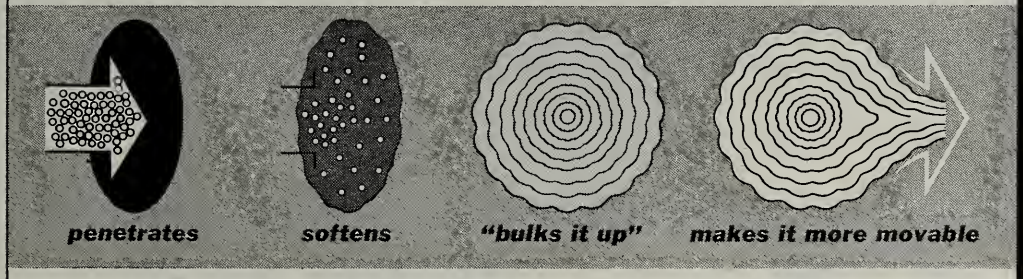
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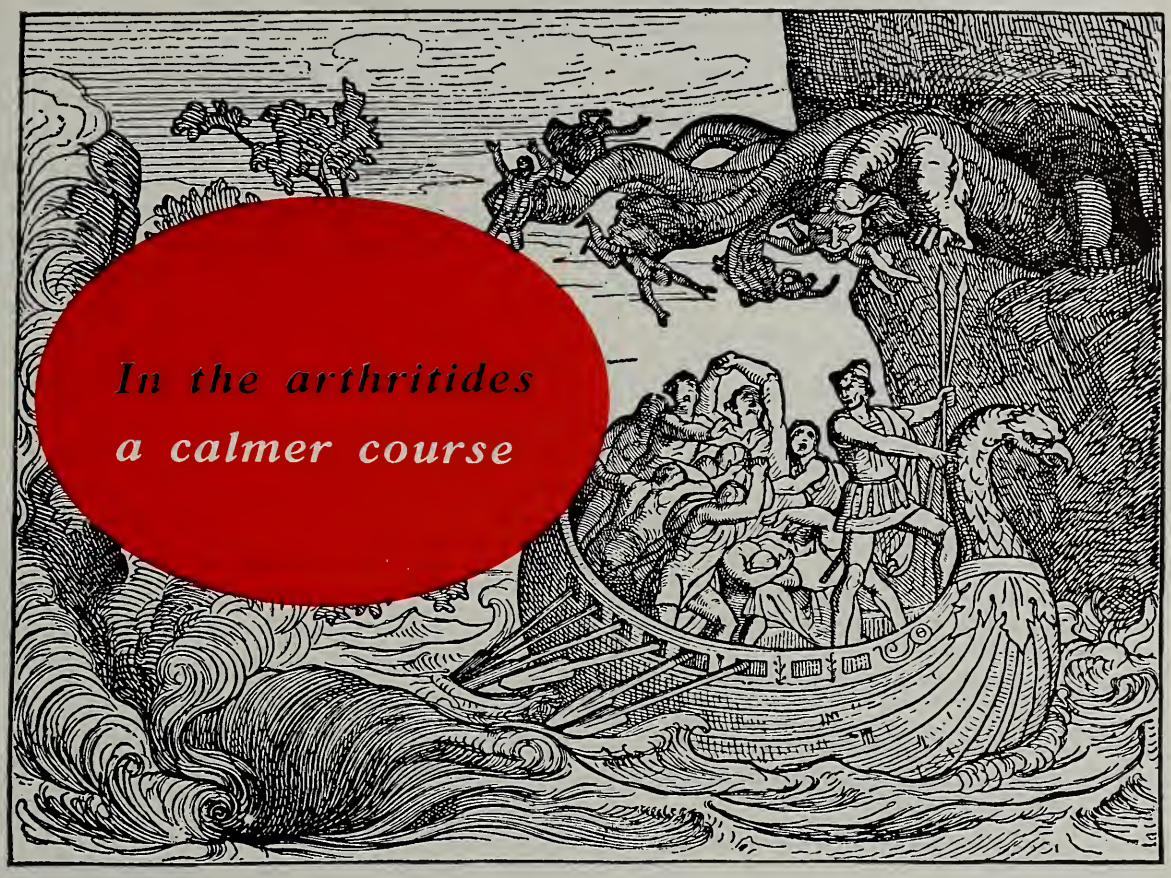

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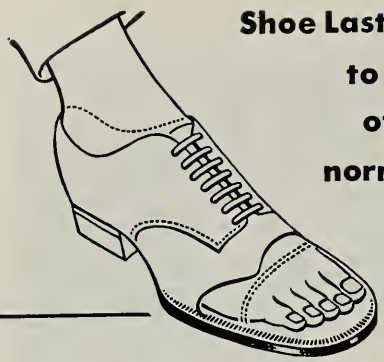
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[1]*Busse, E.A.: Treatment of Rheumatoid Arthritis by a Combination of Cortisone and Salicylates. Clinical Med.* 11:1105

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## Tietze's syndrome

Tietze's syndrome is a painful, nonsuppurative swelling of the costochondral or sternoclavicular junction. Since Tietze's original description in 1921 over 100 patients with chest pain caused by this syndrome have been described by foreign authors. A search for reports concerning this entity in the American literature reveals that Tietze's syndrome has been discussed only twice: the first paper by Motulsky and Rohn in 1953 and the second by Wehrmacher in 1955. In the differential diagnosis of chest pain, Tietze's syndrome should always be considered. Tenderness over the involved cartilage at times is extreme and may be exaggerated by effort as a result of increased thoracic movement. A small, firm, smooth mass may become palpable and visible in the involved costochondral junction. The etiology of Tietze's syndrome is not known. Malnutrition, heavy lifting, repeated trauma from cough, and sudden movements have been implicated as causal factors. The second costochondral junction is involved in about 60 per cent of all cases. The presence of an interarticular sternocostal ligament in this area suggests that trauma or rheumatic disease of this ligament may be an important factor in the etiology of this syndrome. No specific findings have been reported on X-ray examination but radiologic examinations and other laboratory tests are helpful in excluding associated diseases producing chest pain. Tietze's syndrome is rather easily recognized if one just thinks of this possibility. In the differential diagnosis one must consider benign and malignant diseases within the chest wall, in the breasts, the lungs, heart, and mediastinum. In the treatment of this syndrome, local applications of heat, procaine infiltrations, salicylates, and reassurance of the benign character of the disease, give relief in the majority of cases. *Michael Bernreiter, M.D. Tietze's Syndrome Ann. Int. Med. July* 1956.

‹ ›

When you make a mistake, don't look back at it long. Take the reason of the thing into your mind, and then look forward. Mistakes are lessons of wisdom. The past cannot be changed. The future is yet in your power.

— Hugh White

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## Less oxygen for premature infants

With this information implicating oxygen as an etiological factor either by overuse or misuse, a re-evaluation of the care of premature infants at Harbor General Hospital was begun. "Isolette" incubators were being used for all infants under 2,000 gm. and it was general procedure to give oxygen routinely in amounts of six liters per minute and to confine this for several weeks, particularly for the smaller infants. During the year 1952, attempt was made to use somewhat less oxygen and to remove the infants from the high concentrations of oxygen slowly, as was suggested by Szewczyk. However, oxygen still was used in amounts of four liters per minute for several weeks. There was some difficulty in abandoning the concept of unrestricted use of oxygen. There was no pronounced decrease in the incidence of retrolental fibroplasia during the remainder of that year or the next. However, gradually through 1953-54, less and less oxygen was used and for shorter periods. Meanwhile, beginning in July of 1953, all babies under 1,800 gm. were given a special low electrolyte formula as recommended by Hepner and Krause. Routine use of the formula was discontinued in September of 1954. During this interval, retrolental fibroplasia developed in three infants receiving the formula. By early 1954, in the light of continuing reports seeming to indict excessive use of oxygen, the amount of oxygen used for premature infants had been reduced to about two liters per minute and it was given for shorter periods. In late spring of 1954, the use of oxygen was decreased to minimal amounts and then only for obvious indications of respiratory distress, and never longer for a day or two at a time. In June of 1954, use of an oxygen analyzer to determine the oxygen content of the incubators was begun and oxygen concentration was maintained at less than 40 per cent, as was suggested by Lanman, Gordon, and Ashton. At the time of this report there had been no cases of retrolental fibroplasia in 16 months, the most recent case having developed in February of 1954. Even the tiniest babies seem to do as well with the minimal


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amounts of oxygen as they did previously when high concentrations were used for long periods. This agrees with observations made by Engle and Levine in a thorough study of the same subject. *Arthur H. Parmelee, Jr., M.D. et al. Retrolental Fibroplasia. California Med. June* 1956.

‹ ›

A review of housing conditions in any one of our major cities discloses the communicability of housing decay. Like measles among a susceptible population, it spreads persistently from block to block, from area to area, infecting all who have not previously succumbed. Epidemiologically, there is first the contagion of housing endodecay which encourages the use of damp, unlighted, and unventilated rooms and results in room overcrowding and insanitary practices. Second, there is the contagion of housing exodecay which begins with neighborhoods and blighted areas creating shabby properties with decreasing values to be shunned like an exotic plague. *Henry F. Vaughan, Dr. P.H., Am. J. Pub. Health, March,* 1956.


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‹ ›

## A new name

The National Microbiological Institute, one of the seven Institutes of Health, Public Health Service, was redesignated the National Institute of Allergy and Infectious Diseases early in February 1956. Dr. Victor H. Haas is director of the Institute. The renaming of the Institute reflects the importance of new research on allergies and the close relationship of such research with study of infectious diseases. Investigations of allergy are closely allied to the science of immunology, which also is fundamental to investigation of the infectious and parasitic diseases. *Pub. Health Rep. May* 1956.

‹ ›

So long as you live and in whatever circumstances the kaleidoscope of life may place you, think for yourself and act in accordance with the conclusions of that thinking; avoid so far as possible drifting with the current of the mob or being too easily influenced by the outward manifestation of things. Take your own look beneath the surface and don't trust others to look for you. If you will follow this rule consistently, I am sure you will keep out of much trouble, will make the most out of your life, and, what is more, will contribute most of value to the community life.

— Dr. Frank B. Jewett

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Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Send change of address on form 3579 to 1501 W. Washington Road, Mendota, Illinois.

ACHROMATIC



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[1]Posner, A. C., *et al.;* Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

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**References.** 1. Farah, Luis: Int. Rec. of Med. & Gen. Prac. Clin. **169**:379 (June) 1956. 2. Shalowitz, M.: Geriatrics, July, 1956. 3. Robinson, H. M. et al: J.A.M.A. **161**:604 (June 16) 1956.

# The Month in Washington

Washington, D.C.—Regardless of which party organizes the next Congress or who occupies the White House, health and welfare legislation promises to take up considerable time and attention of lawmakers. There is nothing to indicate that the general subject of health has lost its appeal either to the public in general or to men who run for political office in particular.

The national platforms on which the candidates of both parties have been campaigning are somewhat of a blueprint for the type of legislation to come in the 85th Congress, convening next January 3; generally, both parties advocate more rather than less federal participation in health and welfare programs. Here are some of the points in the two platforms:

*Aid to Medical Schools*—The Republicans recommend "federal assistance to help build facilities to train more physicians and scientists" as a supplement to action of the 84th Congress authorizing federal grants to schools and other groups for laboratory research facilities. The Democrats state: "We pledge ourselves to initiate programs of federal financial aid, without federal controls, for medical education."

*Aid to Hospital Construction*—The Republican plank: "Republican leadership has enlarged federal assistance for construction of hospitals." The Democratic plank: "We pledge continuing and increased support for hospital construction programs."

*Medical Research*—Republicans: "We have asked the largest increase in research funds ever sought in one year to intensify attacks on cancer, mental illness, heart diseases and other dread diseases." Democrats: "We shall continue to support vigorously all efforts, both public and private, to wage relentless war on diseases . . . We commend the Democratic party for its leadership in obtaining greater Congressional authorizations in this field."

*Vocational Rehabilitation*—Republicans: "We have fully resolved to continue our steady gains in man's unending struggle against disease and disability." Democrats: "We pledge support to a vastly expanded rehabilitation program for these physically handicapped, including increased aid to states."

*Medical Care*—Republicans: "We have encouraged a notable expansion and improvement of voluntary health insurance, and urge that reinsurance and pooling arrangements be authorized to speed this progress." Democrats: "We pledge . . . increased federal aid to public health services, particularly in rural areas."

*Social Security*—Republicans: "We shall continue to seek extension and perfection of a sound social security system." Democrats: "By lowering the retirement age for women and for disabled persons, the Democratic 84th Congress pioneered two great advances in social security . . . We shall continue our efforts to broaden and strengthen this program by increasing benefits to keep pace with improving standards of living, by raising the wage base upon which benefits depend and by increasing benefits for each year of covered employment."

**NOTES**

Further evidence that federal aid to medical schools will be high on the agenda of the next Congress is the survey underway by the staff of the House Interstate and Foreign Commerce

(*Continued on page* 30)




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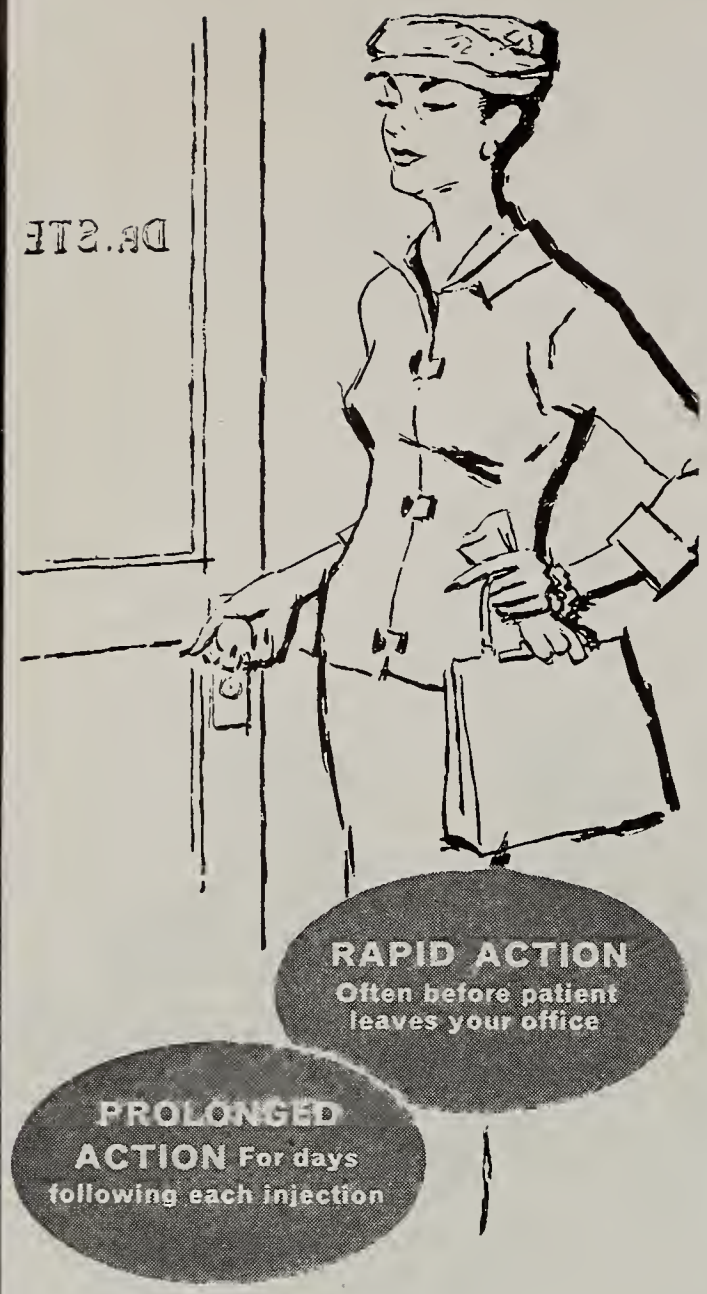
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## WASHINGTON (Continued)

Committee. More than 50 organizations have been sent letters requesting background facts on financial needs of medical schools and the demand for medical school applicants "rather than arguments intended to support or oppose any particular form of federal aid." The information is being gathered as a preliminary to hearings in the next Congress.

Public Health Service announced the availability of 250 traineeship grants for graduate or specialized training of professional public health personnel under the newly enacted Health Amendments (Omnibus) Act. Emphasis is on bringing new and younger people into public health, men and women under 35 years of age. Congress voted $1 million for the program this year. Another 500 traineeships from a $2 million appropriation are offered for graduate nurses in administrative, supervisory and teaching positions.

While Defense Department officials were putting the finishing touches on regulations to carry out the military dependents medical care program, the State Department was working on its own version of a program for furnishing care to about 13,500 dependents of Foreign Service personnel stationed overseas. In most instances, medical and hospital care (with a $35 deductible clause) will be supplied in U. S. military installations.

To aid Defense in setting up fee schedules for military dependents using private physicians and facilities, state medical societies in cooperation with the American Medical Association have been asked to supply data on prevailing medical care charges.

New chief of the PHS Communicable Disease Center at Atlanta, Ga., is Dr. Robert J. Anderson, a career PHS officer who has been serving as assistant chief of the division of special health services.

‹ ›

Current information indicates that there are some what less than 400,000 active tuberculosis cases in the United States at any one time, approximately one-third of which are hospitalized for tuberculosis, one-third are known cases at home, and one-third are undetected cases. Robert J. Anderson, M.D., Pub. Health Rep., Feb., 1956.

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The
ILLINOIS
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Official Journal of The Illinois State Medical Society

OCTOBER, 1956
VOL. 110 NO. 4

# Psychiatric Factors in Therapy of Duodenal Ulcer

S. H. Kraines, M.D., Chicago

Among the several factors influencing duodenal ulcer, psychiatric disturbances play a major role in etiology, in exacerabations, and in therapy.

The immediate factor in the development of peptic ulcer is the action on the stomach mucosa of pepsin-hydrochloric acid. Trauma, infection, burns, fatigue, terminal illness, and certain drugs such as ACTH and cortisone are some of the precipitating physical causes. Emotional tension is a major predetermining factor.

Cushing[1] reported a high incidence of peptic ulcers after intracranial operations. Tumors of the midbrain and diencephalon frequently are associated with gastric or duodenal ulcers. Experimental studies[2,3] have shown that stimulation of the hypothalamus, especially about the tuber cinerium, results in the formation of gastric and duodenal ulcers. Cushing postulates that influences arising in the parasympathetic center in the hypothalamus and conveyed along the vagus nerve are responsible for changes in the gastric mucosa which lead to the development of ulcer.

The mechanism by which emotional tension facilitates the production of a duodenal ulcer involves the hypothalamus and, through secondary stimulation, the pituitary and the adrenal cortex. These neurogenic and hormonal mechanisms are probably involved in the hyperchlorhydria and vasospasm which so often accompanies this illness.

As a result of these neurogenic factors, including those resulting from the action of emotion, there are local gastric changes in motility, in the quantity and quality of gastric secretion, and in vasomotor spasm. We are concerned in this paper not with the local changes but with the central cause; and we regard the central cause not as the hypothalamic but the emotional disturbances.

Strong stimulation of the hypothalamus usually results in a "mass discharge." Intense emotion can act as such stimulation and will produce many symptoms of disturbed autonomic activity such as spastic colitis, tachycardia, muscle tension and headaches. These disturbances are part of the illness of the entire autonomic nervous system, of which peptic ulcer is a specific manifestation.

Vagotomy for peptic ulcer is of value, therefore, by blocking the excessive bombardment of nervous impluses on the gastric mucosa. Valuable as is this procedure, it does not eliminate the role of the hormones (especially from the adrenal cortex) in the formation of peptic ulcer. These hormonal factors are, in large measure,

*Presented at Chicago Chapter, American College of Surgeons, January 19, 1956.*

also secondary to hypothalamic-pituitary disturbance.

The psychic stress that precipitates the formation of a duodenal ulcer may be acute or chronic. The factor of acute stress is seen in such statistics as came out of London during the "blitz."[4] At that time, about three times as many patients were admitted to London hospitals with perforations as in the preceding and succeeding years.

In most instances, it is chronic psychic stress that results in ulcer formation. The common factor of the many forms of such stress is the production of a continuous high level of tension which usually is under excessive personality control and has minimal outlets or release mechanisms. This high level of tension results in overstimulation of the anterior hypothalamic region (governing the vagal system) and, via the pituitary, excessive stimulation of the adrenal cortex. The resulting vagal and hormonal stress stimulates the formation of the duodenal ulcer.

Attempts have been made to describe an ulcer personality; recent studies[5] have shown that such personality groups do not exist. Nor are there specific psychic stresses that are solely ulcer producing. The young business executive is commonly and rightly described as being a good candidate for a ulcer. The great demands made upon such a person, the need for constant self-control in the face of frustrations, the high sense of responsibility - all act to create a high level of tension. But it is not only the business man that is the victim; men of any profession, women, and even chidren have this illness. Women who have ulcers usually give a history of serious domestic difficulties, of sexual frustration, of other emotional conflicts that are the lot of women in society today. Children may develop ulcer; commonly there is excessive friction between the parents, a feeling of being unwanted, or a sense of intense inferiority.

However varied the psychic stresses may be, one element is surprisingly common in patients who develop ulcers, and that is their inability to relieve tension, their over-control of emotions.

Although duodenal ulcers are about four to five times as frequent in men as in women it was not always so.[6] In the 1890's young women were common victims of this illness. Young women of that era were reared in a rigid social code. It was unladylike to express anger, jealousy, or resentment. Women had to show sweetness, pleasantness, and gentleness and all they could do under stress was to break down in tears, to giggle, or to faint. Yet they were driven by the need to get married to obtain a man—for the fate of the unmarried woman in those days was not what it is today. Hence her ulcers. There was too much tension and too little outlet.

It is not only stress that is importanat in the etiology of ulcers but the personality. Two persons under the same stress will react differently. Often, in psychotherapy, stress cannot be changed; it is possible, however, to stabilize the personality. Of the many personality elements that predispose to autonomic nervous system tension (and ulcer) some of the most common are: a sense of frustration, intense feelings of guilt, fear and repressed anger, chronic dissatisfaction and hostility, a strong feeling of insecurity, an excessive sense of responsibility, and driving ambition.

These personality traits become automatic and habitual patterns of reaction, even in the absense of stress; when stress is added, physical symptoms result.

Psychiatric therapy[7] for ulcer rarely should be used alone. Practically always it should be associated with medical care of the specific symptoms; sometimes, only surgical procedures are of therapeutic value. The overall goal of psychiatric therapy in these patients is to reduce emotional tension. The principles include the amelioration of stress and the modification of unhealthy personality traits. The techniques include ventilation, mental hygiene retraining, and deep personality analysis.

To elicit the patient's co-operation in changing his emotional patterns it is essential that he understand their relationship to his physical symptoms—in this instance, to his ulcer. General instructions to the patient to relax or not to worry rarely are of value; most persons wish to be able to do so, but few can do so spontaneously. To help the patient, one must know specifically what his difficulties are. The technique of ventilation consists of permitting the patient to speak freely, not so much of his physical ailments as of his problems and concerns. There is great value to the patient in getting things off his chest, in finding a sympathetic and understanding ear. As the patient talks, the physician

attempts to sort out two sets of facts: The nature and objective validity of the stresses, and the kinds of general habit patterns of reaction that exist.

After the patient has talked himself out, he is questioned about stresses in terms of his work, his mate, his financial situation, sexual problems, and any other general situation of conflict. In order to have the patient deal with these problems specifically, the physician should make a specific list of the stated concerns of the patient. As the patient describes his concerns, the physician again outlines in his own mind the existence of the personality problems, such as are listed above, and he should be aware of how each of these traits operates in terms of the patient's complaints.

The second step in the psychiatric procedure is mental hygiene retraining. If the patient's personality traits (general habit patterns of reaction) can be changed, stresses will no longer be so disturbing. The first procedure along these lines, is to focus the patient's attention on each stress from three different aspects: 1) Defining the problem exactly; 2) deciding on a logical basis the possible solutions; 3) having decided on the solution, he must learn not to review and relive the same problem. It is most important to keep the patient focused on each one of his stresses until he can carry out this three-fold formula. The definition of the problem makes it easier to solve, the decision as to what is to be done removes much of the tension associated with uncertainty, and the training in dismissing a problem, once a decision has been made, prevents constant reverberations of past emotions.

As a rule, it is wise for the physician not to tell the patient what to do about specific problems, for the physician not only leaves himself open to censure should something go wrong, but the solution which he suggests may not be best for the patient. Rather, the physician should encourage the patient to make his own decisions and guide him by questioning. The patient will be better satisfied when he has arrived at his own conclusion. Many stresses that appear insoluble will yield to this Socratic-like method of questioning the patient. Just talking about his stresses crystallizes the problem for the patient and facilitates a solution.

The third step is to venture beyond the specific stress situation and to deal with the basic habit patterns of reaction; these patterns operate automatically in any stress situation and unless these habit patterns can be removed, the patient will continue to be disturbed by even minor pressures. For example, among the more common general patterns of reaction listed above, chronic dissatisfaction and hostility are prominent. During the ventilation period, the physician will have noted how often this attitude (as well as others) appeared, and he will ask the patient how often dissatisfaction and hostility are expressed in other areas. Since few patients see their own emotional responses clearly, it becomes necessary to inquire into their responses in various fields. When a patient comments on some facet in his life which manifests this pattern of chronic dissatisfaction and of hostility, the patient should be made aware how his specific feelings about specific subjects stem from his overall broad general habit pattern of dissatisfaction.

It is helpful to steer the patient's conversation into his relationship with his mate, with his children, with his co-workers; to discuss his views on the achievements of others, as well as his own. As he talks about these specific areas, emphasis should be laid upon the manner in which the general attitude of dissatisfaction operates, on its automaticity, on its pervasiveness. The more avenues the patient can see in which this general attitude operates, the more he will be able to change it.

In each of these instances, the patient is then asked to outline a more ideal pattern for meeting the stress. If he can, in his own words, answer two questions, he will be well on the road toward achieving the therapeutic goal: What his specific attitude should be toward the immediate stress situation about which he is talking; and what his general attitude should be toward similar situations not only in the future, but as he recalls them from the past.

Whenever, in any session, the physician finds the patient reacting according to one of his basic habit patterns, he needs to bring it to the patient's attention. The process of simple repetition often will accomplish what one single erudite discussion will not.

In all of the procedures of changing the basic attitudes of the patient, the physician must al-

ways provide ample encouragement. People are too easily discouraged even from that which they wish most. Fear of consequences is rarely so effective in changing attitudes as is encouragement.

The time spent by the physician in these cases will repay itself in many ways. Not only will there be more lasting results in terms of the ulcer, but the patient will know that he has found not only a physician but a friend. The confidence that the patient has in his physician is one of the cornerstones of therapy.

In many patients, these measures will not suffice. Only by a deep personality analysis can fundamental attitudes be changed. Specialized psychiatric aid is required in these cases. Two other points may be brought up here. Drugs that elevate the mood and relax the patient are of great value, in addition to the antacid and antisecretory medications. Amphetamine, by making the patient feel better, will assist him in changing his attitudes; so will sedatives.

There are a number of patients who suffer from manic depressive depression[7] in whom duodenal ulcers are a depressive equivalent; that is, the primary symptom of this overall depressive mood is ulceration in the stomach. In such instances, electric shock is the psychiatric therapy of choice, and when the depression is alleviated the ulcer disappears.


## SUMMARY

Psychic tension can play a role in the formation of duodenal ulcer through neurogenic and hormonal mechanisms. Psychotherapy necessitates determining the exact nature of the psychic stresses, and assisting the patient to adjust to these stresses. Psychotherapy precedes by: determining the underlying personality traits that predispose the patient to stress reactions; and by specific discussions of each of these traits, achieve general alleviation of tension. Such procedures will not only assist in the therapy of an existing duodenal ulcer but will aid in the removal of associated general autonomic nervous system disturbances.


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# Medical Staff - Board of Trustee Relationship

**Foster L. McMillan, M.D., F.A.C.S., Chicago**

ALTHOUGH having been recently somewhat mentally traumatized by matters pertaining to Medical Staff-Board of Trustee relationship, I will endeavor to avoid any vindictiveness in my remarks concerning this timely subject. However, I do not believe this session should be devoted only to back-slapping or white-washing of deficiencies influencing the ideal relationship between Staff and Trustees.

The Joint Commission on Accreditation of Hospitals has outlined in general, and somewhat specifically, the responsibilities of the Trustees, the Hospital Director and the Medical Staff, but additional integrated or co-ordinated details of organization, responsibilities and liaison are necessary for the individual needs of each hospital.

*The Governing Body*—It is recognized that all phases of the conduct of a hospital are the legal and moral responsibility of the Trustees which incurs responsibility to the patient, to the community, and to the sponsoring organization, if any. Even though generally unrecognized as yet, I believe they must also have a responsibility to the Medical Staff as a whole.

*The Administrator*—The administrator or director of the hospital is the official hospital representative who is directly responsible to the Trustees for the administration and conduct of the hospital within policy limits established by the Board of Trustees. It is his responsibility to provide liaison between the governing body, the medical staff, the nursing staff and other hospital departments and personnel. He, however, should not be responsible for the direction of medical care, teaching or medical research.

*The Medical Staff*—Since governing bodies are rarely qualified medically, responsibility for the medical functions of the hospital must be delegated to and assumed by the Medical Staff.

*President, Medical Board, St. Luke's Hospital Clinical Associate Professor of Surgery, University of Illinois College of Medicine, Chicago, Illinois*

The Medical Staff is responsible to the governing body of the hospital for the quality of all medical care rendered, for the ethical standards of practice in the hospital, and for education and educational standards, if an educational program prevails.

How resolutely all these responsibilities are discharged will depend upon the character of the Board of Trustees, the Administrator and the Medical Staff, implemented by an integrated, effective organization.

The primary purpose of any hospital is to provide the best possible medical care of patients. Many hospitals have assumed additional worthy, but necessarily secondary roles such as medical and nursing education, and even clinical research. The ultimate or ideal effectiveness of achieving such purposes requires full intelligent co-operative liaison between the Trustees, Hospital Administrator and Medical Staff.

From my own observation and experience, I would like to point out some of the obstacles to the ideal relationship between the Staff and the Trustees.

One of the most conspicious obstacles to the ideal relationship in many hospitals, is the imposed Trustee-Administrator "iron curtain" or "dictatorial barrier" between them and the Medical Staff. In the last few years, a glimmer of light has come through this curtain when some Boards of Trustees have established, or asked for a Joint Trustee-Administrator-Medical Staff Liaison Committee, or elected one or more qualified, responsible members of the Medical Staff as Trustees, or appointed the President or officers of the Medical Staff as Advisory Trustees. But, too frequently, these appointments have been mere gestures to placate the Medical Staff in their rightful and earnest desire to have a helpful voice in the administration, planning and future development of the hospital, of which they are one of the most important parts. In the

instances in which these efforts lend only lip-service toward collaboration, arbitration and co-operative action, they have been promptly recognized by the Staff as such, and the relationship has deteriorated disasterously for all.

How effectual indeed it would be, for this iron-curtain, frilled only by idle gestures, to be forever discarded, and for it, substituted the development of a realistic co-operative, well-organized team composed of the Board of Trustees, the Hospital Administrator and the Medical Staff.

Each member of the team must accept and effectively discharge it's own responsibilities. Each must respect the responsibilities of the other members of the team, but not to the point where over-lapping responsibility is disregarded, and not to the extent that matters pertaining to the hospital as a whole are not settled by joint conference or co-operative arbitration by official representatives of each. Each part of the team, individually and as a whole, must assume the responsibility and he held accountable for their words as well as actions.

Another frequent barrier to ideal Staff-Trustee relationship is the lack of confidence or trust between any two parts of this potentially effective team. This confidence and trust cannot be established by demand or edict. It must be deserved. It cannot be established overnight. It is developed, inspired, instilled, or built upon a sum total of such things as attitude, diligence, proved ability, intent, honesty, performance, good judgment, integrity, vision and execution of long-term planning, unselfishness, fairness, loyalty and reasonableness. Once deserved and attained, this confidence can be shaken or destroyed by even a minimal incident.

Diffidence is too frequently created by ill-advised or hasty decisions or utterances by the Trustees, Administrator or by members of the Medical Staff. The appointment and tolerance of an incompetent, ineffectual, or tactless Hospital Administrator by the Trustees will cause inestimable damage to Staff-Trustee relationship.

Domination of the Trustees by an inadequate or unqualified Chairman or President or Hospital Administrator, is quickly sensed by the Medical Staff and will surely lead to a deterioration of confidence and morale.

A Medical Staff which has confidence in its Hospital's Board of Trustees and Administrator is usually a Staff with high morale.

Membership on a Board of Trustees should require a high degree of consecration toward community or public service, and to be effective requires much time, effort, influence and sacrifice, not for any financial gain but only for the satisfaction of doing good.

Too often, Trustees qualify only upon the basis of their social standing or their financial status, without consideration of their effective ability, sincere desire, willingness, and effort to be of service to the community.

Often Trustees are influenced into actions, or hasty decisions, without competent counsel and advice from those most experienced in hospital or medical matters, resulting in ineffectual expenditures pertaining to physical plants or hospital departments, partially or wholly, unsuitable for the purpose intended.

Too frequently, Trustees are appointed or elected insufficiently mature in experience or ability to qualify them to establish policies and make decisions influencing or directing the destinies of an institution so important as a hospital. It is a travesty that these men should be put into a position which may seriously influence the very careers of important men dedicated to the best medical care of patients. Being a Trustee of a Hospital is a serious responsibility.

Trite as the statement may be, bricks and mortar do not make a hospital. In the present day economy, it is even more important than formerly, that the physical plant is modern and planned so that it can be operated with maximum efficiency and economy. But, however modern and well managed, the ultimate reputation is dependent upon it's Medical Staff.

In many instances, financial consideration alone, by the Trustees or Hospital Administrator, as to whether all departments or service elements in the Hospital pay their way or evidence a profit, has caused discontinuance or curtailment of important services. While we must all admit that hospitals should be operated consistent with good business principles, it must be recognized that there are many necessary aspects which cannot be handled strictly in this manner. One Hospital Trustee was heard to remark, in discussion of hospital matters, that in his business, if he could not make a profit on any given commodity,

it was discontinued. The hospital care of patients cannot be entirely on this basis any more than we can practice good medicine strictly on this basis.

There are many other obstacles but in all fairness it is pertinent to mention specifically some of the Medical Staff deficiencies which have contributed to strained Medical Staff-Trustee relationships.

Our own medical organizations have set up rules, regulations and standards of medical care. Standards of staff organization and responsibilities have been established as far as major and general requirements are concerned. But the efficacy with which these are consummated are dependent on so many things which are not spelled-out in any set of standards, rules or regulations.

American medical men are a group of the greatest individualists. This worthy characteristic has resulted in the best medical care in the world, but in the ideal operation and management of a hospital, this individualism must be subjugated, curbed or modified by its own Medical Staff organization or autonomy, to the best interests of all.

Most medical staffs require and rightfully deserve a certain degree of autonomy but it never should be to the point where it dominates to the detriment of the entire hospital organization. Its autonomy should be geared toward being a part of a smooth running, integrated, efficient organization. Strict autonomy of the Medical Staff will prove just as impractical as that of the Nursing Department or the School of Nursing or any other Hospital Department. Imagine the futility of attempting to administer or operate a hospital with each major part or group holding itself apart or aloof from the organization as a whole, no matter whether it be the Governing Body, the Administration, Service Departments or Professional Staff. Because of the influence of our inherent individualism, it is often impossible to obtain unanimity of opinion or accord from the Medical Staff. This trait, when combined with a staff organization which is too democratic, naturally leads to a state of inaction and irresponsibility.

I believe that the best interests of the Medical Staff, as well as to the hospital as a whole, is best served by delegation of authority to its officers and Executive Committee within broad policy limits established by the Medical Staff

For maximum accomplishment and continuity, the Staff Officers, the executive committee, the Joint Liaison Committee and the Professional Department Chairmen of the Staff should serve for a period of at least three to five years. If the Staff realizes that their delegated representatives have vested authority, more intelligent selection of those to represent them will follow. Men with ability, veracity and potential of accomplishment will then be placed in these responsible positions.

The Medical Staff must be responsible to the Board of Trustees and the Administrator for its own discipline as far as the quality of medical care of the patient and the standard of medical ethics is concerned. But, in addition, the Medical Staff must also resolutely maintain discipline of each member or department as applied to conduct, words or actions which deter or destroy the morale of the staff, the nursing or other hospital personnel, or which may reflect adversely upon the governing body, the administration or the hospital as a whole.

Malicious and irresponsible personnel or official accusations, innuendoes, or tirades by individual or groups of Staff members, undermine confidence and respect and destroy morale of the entire hospital. Individual meddling in matters strictly administrative or within the delegated province of the Trustees should not be tolerated. Suggestions, attempts to help, and constructive criticism should be encouraged but it must be expected that they be properly channeled and reviewed, and if found worthy, brought to the attention of the Administration and/or Trustees officially for action.

No administration or Board of Trustees can possibly be expected to respect Staff vacillation of opinion, irresponsibility or unreasonable demands.

The Board of Trustees has a right to expect financial support from each member of the Staff in fund-raising campaigns for the hospital, each to the best of his own ability, but this should never be by assessment unless this responsibility is unfairly assumed and then it should be by Staff action. How can we expect the Board of Trustees to contribute generously and to in-

fluence others to do the same, if we do not participate as generously in proportion to our ability?

There are many, many, other correctable deficiencies which influence Staff-Trustee relationship. I am convinced that the establishment and maintainence of a realistic, effective Joint Liaison Committee, composed of respected and responsible representatives of the Board of Trustees, the Medical Staff and the Hospital Administrator, together with the President or Chief of Staff as an Advisory Trustee, can do more than anything else to sponsor the ideal Staff-Trustee relationship, as well as promote the best interests of the patient, the hospital and the Staff.

Liaison is a bond or connecting link implying co-ordination of activities and intent, with a common purpose and directed toward a common objective.

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# Carcinoma: A Rationalization

**Robert Adelman, M.D., Sterling**

THE following is a rationalization of the problem of carcinoma as seen thru the eyes of a practicing physician. In support, I fall back upon the following by Sir Robert Hutchinson[1]. "As regards the content, one is struck by the great excess of facts and the comparative absence of ideas, generalizations, and hypotheses. There is, in short, too much observation and recording and too little reflection. Hence much of it is like a heap of bricks without any mortar to hold them together."

Because carcinoma is essentially cell growth, in spite of the fact that this growth is uncontrolled and deleterious to the welfare of the host, it is expedient to examine the picture of cellular growth in noncarcinomatous, or normal tissue.

An individual cuts his hand and in a short time, broken cells are replaced and the wound heals. He falls and breaks his wrist, and it is only necessary to reduce and immobilize the fracture and healing will follow. We are thus struck by the realization that it is only when tissue is lacerated or bruised, broken or burned, that a series of changes ensue that is characterized by cell growth; a process we call healing. Clinically this is borne out by the indolent ulcer that we mechanically scrape or chemically irritate, in order to stimulate growth.

In other words, it is felt that cell growth (excluding that in the normally growing child), will take place only as the result of tissue injury, by whatever agent or noxious element this injury may be caused. We postulate then, that under normal circumstances, tissue growth is a chain of events, initiated by cell injury.

Schematically this may be represented by the following:

Let x-ogen be the inactive growth factor present in all cells.

Then, x-ogen + injury = x (the active form)

x + adjacent tissue = growth

Support for the presence of a tissue growth factor can be found in the literature. Sir Howard Florey[2] says, "Pathologists have long been fascinated by the idea that cells, in dying, liberate substances or hormones that stimulate the surviving healthy cells of the same type to produce new cells thru division, thus repairing the original damage." He quotes Wiesner[3] in 1892, and Bier[4] in 1917 who discussed the possible role of "wound hormones" in the healing of human wounds: "The hormones to be considered are, in my opinion, produced at the site of in-

jury, and exert their effect in part locally by diffusion into the surrounding tissues." Similar views were expressed by Marchand[5], Haberlandt[6], and Carrel[7].

Florey further refers to Aub[8] and co-workers, "who noticed that partial hepatectomy of one individual of a pair of parabiotic rats induced mitotic activity in the intact liver of the non-hepatectomized partner in 48-72 hours after the operation." Menkin[9] in his fascinating review of healing, agrees with the possibility of a growth-promoting factor liberated by injured cells.

Basically, carcinoma differs from so-called normal tissue by an outstanding feature: Whereas normal tissue will grow until the original structure has been repaired and will then cease, carcinoma will continue to grow irrespective of the body needs. It is as if a single injury activates a previously inert substance, which stimulates adjacent tissue to proliferate; this proliferation replaces the damaged tissues and then ceases. Let this area be again injured, and again this chain of events takes place. But, carry this process on often enough, and a point is apparently reached where a change takes place. Thus, whereas cellular injury by any noxious agent stimulates growth, oft-repeated injury of the same tissue by whatever agent, raises the stimulating factor to a point that is irreversible.

That these stages exist, is supported by Boyd[10] who says, "Every cell may be considered as potentially malignant. A common characteristic of carcinogenic agents is the long period of time required to produce carcinoma. It would appear that the process of carcinogenesis consists of two phases:

1) a process of long duration which induces a condition of potential malignancy, corresponding to precancerous conditions in man; 2) sudden change of potentially malignant into malignant cells."

That there is a basic denominator underlying carcinoma and normal tissue, inflammation, and repair, is borne out by the following:

*Boyd*[11]: As regards microscopic diagnosis in general, one of the most difficult tasks is to differentiate between sarcoma and inflammatory tissue.

*Gebele*[12]: Steps are: first injury, next inflammation, then carcinoma.

*Virchow*[13]: There is merely a quantitative difference between irritation and inflammation.

*Ackerman and Regato*[14]: Apparently any cell or, more likely, any group of cells, having the property of growth and reproduction can, under proper stimulation, become the ancestor of cells that manifest characteristics associated with neoplasia.

Thus we put forth another principle: Oft-repeated cell injury of the same tissue in any individual, if continued sufficiently, will result in neoplastic reaction.

Let us return to normal tissue. Why does normal tissue when injured grow to a certain point and then cease? If injured tissue releases a stimulating factor for growth, is it not feasible that growing cells elaborate an antigrowth factor? Schematically:

x-ogen (the inactive form) + injury = x (the active form)

x + tissue = tissue growth;

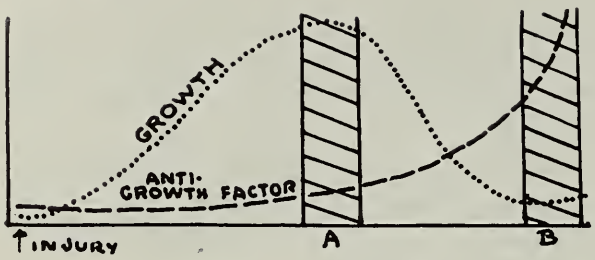
tissue growth elaborates an antigrowth factor (and an equilibrium is reached)

What then happens in carcinoma? It is as if the antigrowth is exhausted and growth continues unrestrained. Ackerman and Regato[15] voice this in the following: "The extraordinary property of tissue cells is not that they occasionally assume neoplastic properties, but that in most instances they "know" exactly when to stop growing following injury, during regeneration, and during embryonic development. Rather than a stimulation, cancer can be considered as the loss or absence of certain inhibiting substances."

Menkin[16] adds his support when he says: "It is conceivable that a neoplasm is in large part the result of some cellular disequilibration either in the form of injury as seen in long standing inflammation, hormonic imbalance, or even in a virus infection with the consequent release from the cell of a growth promoting factor or factors. When this or these factors are superimposed on either a genetically susceptible organism, or in the presence of a specific carcinogenic substance, the result may be a malignant process."

From this line of reasoning, there would follow an interesting plan of attacking carcinoma. In normal tissue, following an injury, growth shortly reaches its peak, and then subsides. According to the above stated assumption, the antigrowth or inhibitory factor increases and

reaches its peak. This can be shown on a graph as follows:




Now, if shortly after tissues are injured, an extract be prepared (at A ), the growth factor should be at its height, and if injected into an animal, should stimulate growth. However, if the injured tissue be allowed to heal, the antigrowth factor should be at its maximum (B), and the tissue extract prepared from it at this point, if injected into carcinomatous cells, should inhibit growth.

That we may hope to one day be able to control cancer, is adequately stated by Ackerman and Regato[17]: "An oft-repeated dictum is that cancer is an irreversible process; once cells have acquired neoplastic characteristics, they cannot revert to normal growth. This deduction, used in the mutation theories of cancer, lacks proof and may well apply only to the last, frank stage of the process."


## SUMMARY

1. The consensus of pathologists, going back to 1892, is presented, maintaining that a tissue growth-factor is liberated from injured cells.

2. A postulate that under normal circumstances, tissue growth is a chain of events initiated by cell injury.

3. A postulate that oft-repeated cell injury, of the same tissue in any individual if continued sufficiently will result in neoplastic reaction.

4. A postulate that normal tissue not only releases a growth-promoting factor, but also an antigrowth, or growth inhibitory factor.

5. A plan of attacking carcinoma is presented: Making an extract from injured tissue, after it has healed, and when the antigrowth factor should be at its height.



Sterling-Rock Falls Clinic


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## One out of every ten

Eleven dollars out of every $100 spent by American consumers for services are for health services and death expenses. A Commerce Department report discloses that in 1955 consumer expenditures for services totalled $91.2 billion, of which $10.1 billion came under the heading "Medical Care and Death Expenses." Hospitalization and drugs, as well as doctor bills, are classified under medical care. The only two types of services which surpassed this grouping dollar-wise in 1955 were those incidental to housing ($31.2 billion) and personal business ($12.5 billion). Lesser sums were spent for transportation ($7.4 billion), recreation ($4.9 billion), religious and welfare activities ($3.4 billion), and various other categories of services. Between 1929 and 1955, consumer outlay for medical care and death expenses increased 260 per cent —from $2.8 billion to $10.1 billion. This represents the greatest rise of all categories for this 26 year period. *Medical and Death Expenses Up. GP. July* 1956.

# Palliative Vagatomy for Nonresectable Bronchogenic Carcinoma

**Douglas R. Morton, M.D., F.A.C.S., Elgin Neil C. Andrews, M.D., Karl P. Klassen, M.D., F.A.C.S. and George M. Curtis, M.D., F.A.C.S., Columbus, Ohio**

A REVIEW of the pertinent literature shows that a large percentage of cases of bronchogenic carcinoma is nonresectable at exploratory thoractomy. At present there is little to add to the comfort of these patients during the terminal stage other than symptomatic treatment and irradiation. In previous communications[6,7,8] the authors presented a new concept of the neurophysiology of the bronchial tree which affords a basis for the performance of an additional procedure in an attempt at palliation of these unfortunate patients.

During the last 10 to 15 years bronchogenic carcinoma has attracted more attention than previously, mainly because of the increasing frequency of this lesion. Its insidious onset is largely responsible for failure in early recognition of the lesion and subsequent delay of definitive therapy. Of 1,016 consecutive cases reported by Edwards[4] surgery was feasible in only 17 per cent (173 cases). Of the 173 cases subjected to surgery 41 per cent (70 cases) were considered to be resectable; whereas 59 per cent (103 cases) had exploratory thoractomy only.

In another series of 155 patients Churchill[2] reports that surgery was performed in 34 per cent (52 cases); and of those operated upon, resection was possible in only 52 per cent (27 cases). Clagett and Brindley,[3] reporting from the Mayo Clinic, state that of 90 cases subjected to exploratory thoractomy, resection was possible in only 50 per cent (45 cases). In 1948 Oschner et al[9] reported a series of 307 cases subjected to surgery. Although 195 received the benefit of resection, 70 per cent of these were considered to be palliative. In the remaining 112 cases the lesion was sufficiently advanced that exploratory thoractomy only was performed. In the last 100 consecutive patients operated upon in our clinic, 51 per cent were found to be nonresectable.

These statistics indicate that approximately 50 per cent of patients subjected to surgery are found to be nonresectable. It is in this latter group that the authors believe some palliation can be achieved by transection of the homolateral vagus trunk immediately below the origin of the recurrent laryngeal nerve.

Analysis of several series of patients reveals that two of the more frequent and distressing symptoms are cough and chest pain. Reference to Table 1 indicates that in a large collected series the average frequency of cough was 75.8 per cent and that of chest pain, 58.0 per cent. Obviously alleviation of these two symptoms during the terminal phase would add measurably to the comfort of those patients found to be nonresectable at the time of exploratory thoractomy. We have found that section of the homolateral

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TABLE 1
Incidence of Cough and Chest Pain in Patients with Bronchogenic Carcinoma

| Author | Cough | | | Chest Pain | | |
|---|---|---|---|---|---|---|
| | Total No. in Series | No. with Cough | % | Total No. in Series | No. with Chest Pain | % |
| Brines & Kenning (1) | 73 | 64 | 87.0 | 73 | 44 | 60.2 |
| Frissell & Knox (5) | 46 | 41 | 91.0 | 46 | 33 | 71.7 |
| Ochsner et al (10) | 58 | 52 | 89.7 | 58 | 18 | 31.0 |
| Overholt (11) | 165 | 136 | 82.0 | 165 | 70 | 51.4 |
| Simons (12) | 1,376 | 996 | 72.3 | 1,439 | 861 | 59.8 |
| Morton et al | 100 | 90 | 90.0 | 100 | 66 | 66.0 |
| Average | | 75.8% | | | 58.0% | |

vagus trunk immediately below the origin of the recurrent laryngeal nerve has afforded relief of these symptoms in the majority of patients.

The physiologic basis and rationale for the performance of this procedure is briefly reviewed. In a previous communication[7] it was demonstrated that electric stimulation of the tracheobronchial tree during bronchoscopy resulted in pain. The referral of such pain was consistent and symmetric. In general, stimulation of the posterior wall of the main bronchi referred pain to the homolateral anterior chest wall within 4 cm. of the sternum or to the anterior cervical region within 2 cm. of the midline.

Stimulation of the posterior wall of the trachea at a point 1 cm. proximal to the carina resulted in referral of pain to the anterior midline at a point extending from the larynx to the xiphoid. Since establishing that the mucous membrane of the tracheobronchial tree is sensitive to pain, it is our belief that the symptom of chest pain in these patients, especially in the absence of pleural involvement, is largely of bronchial origin. Confirmation of this belief is provided by anatomic studies which reveal that approximately 75 per cent of bronchogenic carcinoma arise in the main bronchi.

In subsequent studies utilizing the same technique, it was demonstrated that pain of bronchial origin was abolished on the homolateral side in the majority following transection of the vagus trunk immediately below the origin of the recurrent laryngeal nerve[8]. These findings suggest that the afferent fibers that transmit pain from the bronchial tree are carried by the homolateral vagus nerve. Concomitant studies in this group of patients revealed that the cough reflex arising from stimulation of the homolateral bronchial tree had been abolished, whereas the cough reflex from the contralateral bronchial tree had remained intact[6]. Four agents (foreign bodies) were utilized in stimulating the nonanesthetized bronchial mucosa: a bronchoscope, an electrode, a tracheal catheter, and lipiodol. In all patients, introduction of the foreign body into the homolateral main bronchus was not accompanied by coughing; whereas their introduction into the contralateral main bronchus resulted in violent paroxysmal coughing. These findings suggest that the afferent fibers transmitting bronchial impulses resulting in cough are carried by the homolateral vagus nerve.

On the basis of these studies the homolateral vagus trunk was transected immediately below the origin of the recurrent laryngeal nerve in 25 patients with nonresectable bronchogenic carcinoma at the time of exploratory thoractomy. In some of the patients found to have pleural extension of the tumor, crushing or transection of the appropriate intercostal nerves was performed. Adequate postoperative follow-up was possible in 18 of these cases (Table 2).

Representative cases are herewith presented:

Case 1. A.B., a 46 year old white male, was hospitalized complaining of productive cough, left anterior chest pain, chills and fever, and exertional dyspnea of 9 months' duration. X-ray films of the chest demonstrated a tumor mass in the left hilum, and bronchoscopy was confirmatory. There was no evidence of peripheral metastasis. Exploration revealed a nonresectable lesion.

A high left vagotomy was performed. The intercostal nerves adjacent to the incision were crushed posteriorly prior to closure. Postoperatively he was seen at monthly intervals. He remained free of chest pain and cough until the 11th postoperative month, when he complained of dyspnea, dysphagia, and hiccup. Barium swallow demonstrated extension of the tumor into the esophagus. During the 13th postoperative month he was hospitalized in a terminal state with considerable cough, chest pain, dyspnea, cachexia, and left shoulder pain, and expired shortly thereafter.

Case 2. H.R., a 54 year old white male was hospitalized with a history of an oppressive pain in the right anterior chest and productive cough following an attack of "flu" 3 months prior to admission. X-rays demonstrated an enlarged right hilar shadow with segmental atelectasis of the right upper lobe. There was no evidence of peripheral metastasis. Bronchoscopic biopsy was reported as squamous cell carcinoma. Exploration revealed a nonresectable tumor, and a high right vagotomy was performed. The patient was seen frequently until expiration 8 months later. He remained free of cough and chest pain until his last month of life, at which time he complained of right brachial plexus pain, mild cough, dyspnea, and peripheral edema. Narcotics were necessary only during the terminal two weeks.

Case 3. H.A., a 52 year old white male was hospitalized with a history of severe productive cough, hemoptysis, and right anterior chest pain of two months' duration. X-rays revealed an atelectatic right upper lobe, and bronchoscopy demonstrated a polypoid tumor arising from the right upper lobe bronchus. There was no evidence of peripheral metastasis. Exploration revealed a nonresectable tumor, which proved to be undifferentiated carcinoma on frozen section. Since tumor extension prevented identification of the vagus trunk, a high vagotomy could not be performed within the thorax. The thoractomy incision was closed after crushing the fourth, fifth, sixth, and seventh intercostal

TABLE 2

RESULTS OF HIGH VAGOTOMY IN 18 PATIENTS WITH BRONCHOGENIC CARCINOMA

| Patient | Symptomathology: Cough | Symptomathology: Chest Pain | Post-Operative Data |
|---|---|---|---|
| H. A. | + | + | Survived 8 months. Free of cough and chest pain until terminal month. |
| A. B. | + | + | Survived 13 months. Free of cough and chest pain for 11 months. Severe symptoms terminally. |
| L. G. | + | + | Survived 6 months. Free of cough until expiration. Developed contralateral chest pain due to metastasis in 4th month. |
| E. G. | + | 0 | Survived 10 months. No chest pain. Developed mild cough and pain in left arm during terminal month. |
| J. G. | + | + | Survived 4 months. No chest pain. Developed moderate cough terminally. |
| D. H. | + | 0 | Survived 6 weeks. No cough or chest pain. |
| H. L. | + | + | Survived 8 months. Mild cough and moderate chest pain terminally. |
| J. M. | + | + | Survived 7 months. No cough or chest pain. |
| H. P. | + | + | Survived 4 months. No chest pain. Developed cough terminally. |
| E. P. | + | 0 | Survived 8 months. During convalescence $Co^{60}$ needles inserted into main bronchus for 6 days without producing cough. Developed mild cough terminally. |
| L. P. | + | + | Survived 13 months. No cough. Developed shoulder and abdominal pain in 9th month. |
| M. P. | + | + | Survived 13 months. Developed moderate cough and chest pain terminally. |
| H. R. | 0 | + | Survived 8 months. Developed cough and brachial plexus pain terminally. Required narcotics during last 2 weeks only. |
| E. S. | + | + | Survived 10 months. No cough. Developed shoulder pain terminally. |
| F. S. | + | + | Survived 6 weeks. No cough or chest pain. |
| S. S. | + | + | Survived 3 months. No cough or chest pain. |
| P. T. | + | + | Survived 2 months. No cough or chest pain. |
| R. Y. | + | + | Survived 4 months. No chest pain. Developed mild cough at night terminally. |

nerves posteriorly. A cervical exploration was performed; the vagus nerve was identified in the carotid sheath and transected. Other than the resultant hoarseness, the postoperative course was benign. The patient was seen frequently and he remained free of cough and chest pain until the terminal four weeks, during which time he developed a moderate cough, chest pain, and dyspnea. He expired eight months postoperatively.

Case 4. D.H., a 54 year old white male was hospitalized with a history of cough, weight loss of 25 pounds, and general malaise of four months' duration. X-rays demonstrated atelectasis of the anterior segment of the right upper lobe. There was no evidence of peripheral metastasis. Exploration and biopsy revealed a nonresectable tumor, and a high right vagotomy was performed. He was discharged on the seventh postoperative day subjectively improved, but was readmitted six weeks later because of repeated episodes of severe epistaxis. The platelet count was 45,000 and bone marrow studies revealed metastatic malignancy. He expired 24 hours after readmission. At no time subsequent to surgery had he noted cough or chest pain.

Case 5. E.G., a 57 year old white male was hospitalized complaining of a chronic productive cough, fatigue, and a weight loss of 35 pounds of eight months' duration. X-rays demonstrated a segmental atelectasis of the left upper lobe with a shift of the mediastinum to the left. Slight fixation of the left hilar structures and bleeding from the left main bronchus were observed during bronchoscopy. There was no evidence of peripheral metastasis. Exploration and biopsy revealed a nonresectable carcinoma. A high left vagotomy was performed. Nine months later the patient complained of slight cough and pain in his left arm. He expired the tenth postoperative month.

Case 6. R.Y., a 64 year old white male was hospitalized complaining of cough, fatigue, dyspnea, and right posterior chest pain of 1 year's duration. X-rays demonstrated segmental atelectasis of the right lower lobe.

Bronchoscopy revealed an irregular polypoid mass in the right lower lobe bronchus which on biopsy proved to be carcinoma. There was no evidence of peripheral metastasis. Exploration revealed a resectable lesion which infiltrated the adjacent parietal pleura. A high right vagotomy was performed; and in addition the fifth, sixth, seventh and eighth intercostal nerves were crushed. In the following three months he experienced no chest pain; only mild cough upon retiring at night and a weight gain of 4 pounds. He expired four months postoperatively.

## DISCUSSION

Reference to Table 2 demonstrates that high vagotomy resulted in successful palliation of cough and chest pain in the majority of patients with nonresectable bronchongenic carcinoma. No complications could be attributed to the performance of this procedure.

The postoperative progression of tumor growth and its resultant bronchostenosis undoubtedly leads to stagnation of secretions distal to the lesion. In some instances, mild to moderate cough recurred during the terminal stage of life, which we believe was due to spillage of accumulated secretions into the trachea and the contralateral innervated bronchial tree. In others, recurrence of chest pain was noted several months postoperatively, which appeared to be directly proportional to the length of survival. These findings suggest possible regeneration of the vagus nerve or involvement of other nerve pathways by an enlarging tumor mass.

Inasmuch as the cough reflex, ciliary activity, and the respiratory movements of the bronchi are considered to be the more important physiologic mechanisms in the maintenance of a patent and efficient tracheobronchial tree, one might well wonder whether or not abolition of the cough reflex impairs the clearance of bronchial secretions. In order to evaluate the efficiency of clearance of secretions from the homolateral denervated bronchial tree, bronchographic studies were performed.

These patients serve as their own controls in that clearance of secretions from the denervated homolateral bronchial tree can be compared with the clearance of secretions from the normal innervated contralateral bronchial tree. Caution was exercised in the performance of the bronchograms so that an equal amount of lipiodol was introduced into each side of the bronchial tree by using a nasotracheal catheter. One to seven days after bronchography, PA chest X-rays were

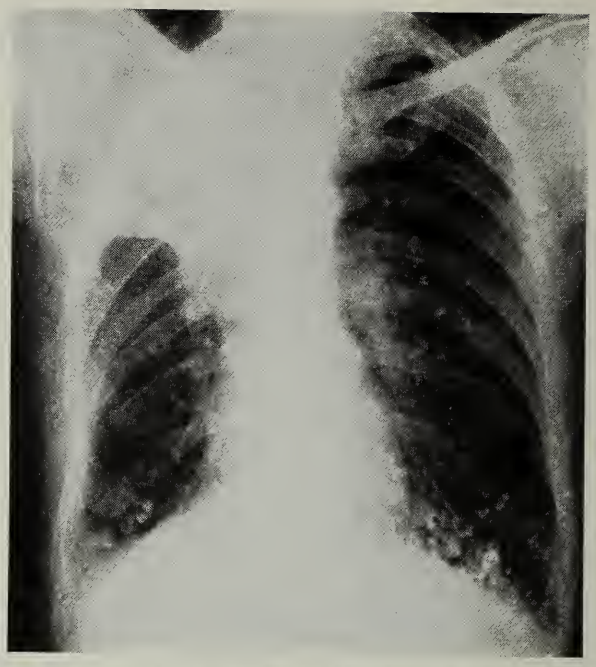


**Figure 1. Roentgenogram taken 4 days after bronchography. Lipiodol is seen in a basel alveolar distribution bilaterally without excessive pooling on the side of the right vagotomy. Note density of the nonresectable tumor in the right upper lobe.**

obtained in order to determine the residual amount of radio-opaque material remaining in both sides of the bronchial tree. If the residual oil in each side were found to be the same it could be assumed that unilateral vagus section had not impaired the efficiency of clearance of secretion from the homolateral bronchial tree (Figure 1). In all cases, with one exception, there was no pooling of secretion, such as would be evidenced by a greater residuum of oil on the homolateral side. In the one patient in whom a moderate pooling of oil was noted in the homolateral basal segments, there was a concomitant limitation of diaphragmatic movement. It was thought that this prevented complete bronchial clearance, since full activity of the diaphragm was present on the contralateral side.

During the initial stages of this study the occurrence of so-called vagovagal reflex, cardiac arrythmias, and cardiac arrest was considered to be a serious possibility but these complications were not encountered. Anatomic studies demonstrated that in sectioning the right vagus trunk immediately below the recurrent laryngeal branch, the vagus nerve was transected proximal to the origin of the right thoracic cardiac branch. To determine whether or not this procedure

caused any cardiovascular effects, continuous electrocardiographic tracings were employed during surgery. Comparison of these tracings to those obtained preoperatively and postoperatively revealed no changes secondary to vagotomy at this level.


## SUMMARY

1. A brief review of the literature pertaining to the symptomatology and resectability of bronchogenic carcinoma is presented. In a large collected series the average frequency of cough was 75.8 per cent and that of chest pain, 58.0 per cent. In approximately 50 per cent of the patients subjected to surgery the lesion was found to be nonresectable.

2. A new concept of the neurophysiology of the bronchial tree is briefly reviewed. This affords a physiologic basis for the performance of a palliative high intrathoracic vagotomy immediately below the origin of the recurrent laryngeal nerve in an attempt at palliation of the distressing symptoms of cough and chest pain in patients deemed nonresectable at the time of exploration.

3. Homolateral high vagotomy was performed in 25 patients found to have nonresectable bronchogenic carcinoma at the time of exploratory thoractomy. The results in 18 patients are reported, revealing substantial alleviation of cough and chest pain. No complications attributable to the performance of this procedure were noted. Seven cases were lost to follow-up.

Addenda: The authors stress that they do not advocate palliative vagotomy for the obviously inoperable case of bronchogenic carcinoma, but only in those patients found to be nonresectable at the time of exploratory thoracotomy.



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## Signs of addiction

There are no pathognomonic signs of addiction besides puncture marks, scars, sclerosis of veins, or other evidence of repeated injections. Although the barbituates and alcohol produce unmistakable signs of intoxication, the opiates do not cause mental confusion, emotional stability, nystagmus, and ataxia after tolerance has been developed. Similarly, pupillary constriction cannot be relied upon for diagnosis. Although there are reliable tests to detect morphine and cocaine in the urine, these tests are extremely complex and time-consuming, and are not ordinarily available to the general practitioner. N-allylnor morphine, an antidote for morphine, is now the subject of current research as a test for drug addiction. The drug produces signs of abstinence in addicts within 15 minutes after administration; however, the limits of reliability and safety have not been sufficiently established to justify general use for diagnostic purposes. *Drug Addiction. Psychiat. Bull. Summer,* 1956.

# Chronic Ulcerative Colitis: Histochemical Studies

**Michael H. Streicher, M. D.*, Hubert R. Catchpole, Ph.D.†, and Conrad Levi Pirani, M.D.§, Chicago**

THE brief report of Levine, Kirsner and Klotz[1] indicated a new direction in studies of ulcerative colitis. While literature offers many excellent histopathological studies of the colon, we do not consider the evidence satisfactory for the specificity of the lesion of ulcerative colitis *per se*.

Among others, Warren and Sommers[2] described the essential pathology of ulcerative colitis and differentiated the more common crypt-abscess type from an essentially vascular phenomenon of the periarteritic (nodosa) or thromboangiitic type. Levine *et al* added to this description an account of biopsy specimens treated by newer histological and histochemical techniques, in which changes in basement membrane and ground substance of the connective tissue were the prominent findings. On the basis of these changes, they suggested that ulcerative colitis could fall into the collagen disease group. The present study was initiated as a prelude to further analysis of this disease entity, and for comparison with other types of inflammatory change that may be encountered in the lower bowel. Methods comparable to those of Levine *et al* were employed utilizing a fairly large series of normal and affected patients.

We selected 28 patients with ulcerative colitis and 15 normal subjects. Each patient was observed at intervals for long periods and was investigated roentgenologically and proctoscopically. Patients under study did not receive medication and were free of prolonged inflammatory or chronic disease of any other character.

Chronic ulcerative colitis patients presented symptoms of diarrhea, loss in weight, abdominal cramping, and blood in the stools. Symptomatology varied a good deal in severity, but as a rule was of the same pattern type. On proctoscopic examination, following the classification of Logan, positive cases of ulcerative colitis were graded as type 3 or 4 depending on the degree of involvement of the mucosa. Type 4 represents the more advanced stage, with ulcerations and alterations in the caliber of the lumen of the colon. Clinical and proctoscopic diagnoses were confirmed by roentgenologic study of each patient following a barium enema. In five of the 28 positive cases, the roentgenologic study failed to confirm the clinical and proctoscopic diagnosis, implying that the colon was not advancedly involved and that the pathologic process had not extended to the outer serosal layer of the colon. The 15 controls were negative for any pathologic findings clinically, proctoscopically, or roentgenologically.

Biopsies of the mucosa from upper and lower segments of the colon were obtained through the proctoscope in patients with disease at a time when specific medication was being withheld. Tissues from corresponding sites were also taken from patients who were clinically normal. The biopsy fragments were placed on slips of paper and instantaneously frozen in isopentane chilled to —180° C. by means of liquid nitrogen. These were then dehydrated in vacuo at −30° C. When dry, the fragments were infiltrated *in vacuo* in pure paraffin melting at 56-58° C. and then embedded in paraffin. Sections at 6 micra were affixed to slides lightly coated with egg albumen by finger pressure and brief warming.

Cellular and morphological details were studied in hematoxylin and eosin stained sections. Visualization of mucoproteins and mucopolysaccharides of the connective tissue was accomplished by use of the Hotchkiss-McManus technique[3,4]. The ground substance of connective tissue is stained pink and basement membranes in various shades of deeper red or purple. Mucus in the gland cell stains bright reddish purple;

**Deceased.*

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TABLE 1.
Histopathologic Findings of Specimens of Colon

| No. of Patients | Colon Biopsy | Component elements identified on H and E stain | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Degree of inflammatory changes in cells | | Gland hyperplasia | | | | | |
| | | severe | mild | severe | medium | Fibrosis | Abscess | Ulceration | Edema |
| 28 Ulcerative Colitis | upper | 19 | 5 | 12 | 8 | 2 | 4 | 5 | 4 |
| | lower | 17 | 5 | 11 | 3 | 3 | 2 | 4 | 4 |
| 15 Normals | upper | | 10 | | 3 | | | | 7 |
| | lower | | 10 | | 3 | | | | 7 |

and cellular granules consisting, for example, of mucoprotein or of glycogen are stained red[5]. The latter may be differentiated by the use of amylase, which dissolves glycogen. Total and water soluble mucoprotein material were assessed by a standard method used in this laboratory[6].

In the microscopic study of hematoxylin and eosin stained slides, note was made of the following characteristics: epithelial and glandular cell morphology; extent of ulceration if present; extent and type of inflammatory cell infiltrates; and fibroblastic reaction. In the Hotchkiss-McManus treated sections, special attention was given to subepithelial, glandular, and blood vessel basement membranes; ground substance; granules of fibroblasts and macrophages; and solubility of connective tissue elements.

Histological findings in the colonic mucosa and submucosa in 15 normal and 28 ulcerative colitis subjects, judged by clinical criteria, are summarized in Table 1. In the first group, the glands and their lining cells appeared normal in size, structure, and number and only a small number of lymphocytes was noted between the glands and the submucosa. Small lymphoid follicles appeared as a normal finding. Congestion of blood vessels and edema of the interstitial tissues were seen in about half the cases, and in practically all it was possible to see infiltration of chronic inflammatory cells diagnosable as minimal, slight, or mild. The occurrence of these changes in normal individuals may indicate a relatively unstable situation in the lower bowel, in which its particular functions of high motility combined with local factors of distention and high bacterial content may predispose it to subclinical alterations of an inflammatory nature.

In ulcerative colitis, much greater inflammatory features were noted in the mucosa and submucosa. There was a moderate to heavy accumulation of chronic inflammatory cells, often accompanied by small abcesses and ulceration of the mucosa permitting a definite diagnosis of ulcerative colitis of greater or less severity or chronicity. In five patients, inflammation appeared to be chronic, with no ulceration and these were classified as chronic colitis. In practically all cases where marked inflammation was present, the glands appeared formed by hypertrophic cells, their structure was abnormal, and frequently their number was greatly reduced. The cells involved in the inflammatory process included lymphocytes, polymorphonuclear leucocytes, eosinophilic leucocytes, and in the more chronic cases, plasma cells and histocytes.

Study of sections stained with the periodic acid-fuchsin method permit an appraisal of certain elements of the connective tissue not seen in the routine examination. The most striking changes concern the basement membranes of glands and blood vessels and of the epithelium of the colon (in some cases the latter was not seen owing to faulty orientation of the section).

In normal material, the glandular basement membrane stains as a prominent red line, sharply delimited from the unstained basal portion of the gland cells containing the nuclei. Vascular basement membranes are observed in small vessels of the mucosa as prominent components of the perivascular connective tissue. The interstitial ground substance stains a light pink in normal subjects; in certain sites, it appears to be homogeneous and dense. The surface epithelial basement membrane was rated as moderately to heavily prominent. Special attention was given to fibroblasts which appeared to be disposed con-

TABLE 2.
Histochemical Findings in Colon Mucosa

| Number of Patients | Periodic acid—leucofuchsin method applied to frozen-dried tissue | | | | |
|---|---|---|---|---|---|
| | Basement membrane | | | | |
| | Glands | Vessels | Ground Substance | Multinucleated Pleomorphs | Mucus |
| 28 Ulcerative Colitis | fragmented, frayed or absent | less clear, generally intact | pale pink sparse | numerous | uneven or paler granules or not definitely granular |
| 15 Normals | prominent, intact | clear, intact | bright pink abundant | few or scattered | dense, deep red-purple granules |

centrically in the vicinity of glands in routine sections. In normal material, many of these were seen to be rather heavily filled with periodic-acid leucofuchsin positive granules. On the other hand, macrophages containing similarly staining but dense and homogeneous material were scarce (Table 2).

In ulcerative colitis cases, the basement membrane of glands provided the most conspicuous alteration from the normal in being far less prominent, frequently fragmented, or even absent. The vascular basement membranes in the mucosa shared this change. The ground substance was somewhat harder to characterize; it could be faint pink staining or occasionally darker staining; homogeneity was harder to recognize owing to the more frequent edema. The fibroblasts in the vicinity of the glandular basement membrane appeared to be less granular; cells, presumably macrophages, containing dense homogenous periodic acid fuchsin staining material tended to be numerous in the interstitial connective tissue. The surface epithelial basement membrane, where observed, tended to be faint, fragmented, or absent. A resume of these changes is given in Table 2.

In scanning carefully the slides of ulcerative colitis patients, it was possible occasionally to observe an appearance that may represent a tendency to glandular regeneration. Then, isolated areas of glands with a well marked basement membrane were seen, associated with granule-containing fibroblasts in the near vicinity.

The appearance of mucin in gland cells, staining red or purple with the periodic acid leucofuchsin reagent, presented some interesting features. Mucigen granules were described by Gersh[5] in goblet cells following treatment in all respects comparable to ours, as discrete, spherical, brilliant red bodies. Similarly, in glands of the normal colon, the mucin granules were usually resolvable under high powers of the microscope into uniform discrete spheres of high color intensity. In ulcerative colitis cases, the mucin frequently appeared as more or less dense masses, not always resolvable into distinct granules. Occasionally there was an appearance as if the granules had become somewhat swollen in life, blurring their outlines. Along with the loss of glands and the somewhat changed morphology of individual glands, the cells appeared to contain less mucin than did normal cells.

Pairs of slides of normal and ulcerative colitis tissues were prepared and stained simultaneously to observe the effect of buffer on the basement membrane and ground substance. As already noted, with the ulcerative colitis material one tends to start with a less marked staining of basement membrane and ground substance in unextracted sections; this may become pronounced after buffer treatment. In normal tissue, treatment with buffer will leave the ground substance generally lighter; the glandular basement membranes may be unchanged or somewhat extracted and are sometimes swollen; vascular basement membrane is not greatly changed. The granules of normal fibroblasts often are not greatly affected by buffer treatment; mucin granules swell and mucin is dissolved in part by one hour buffer treatment, leaving mucin cells with a highly vacuolated appearance. Material in

macrophages also is extracted.

Following buffer extraction, the basement membranes of glands in ulcerative colitis may present a washed out, fragmented appearance; those of blood vessels are not always greatly affected. The ground substance will in general be light, washed out, and nonhomogenous. Granules in fibroblasts usually are not seen following buffer. The material in the numerous macrophages is washed out and mucin, as in the normal, is dissolved and the cells appear vacuolated.

## DISCUSSION

Levine, Kirsner and Klotz[1] have presented a new concept of the pathogenesis of ulcerative colitis which would group it with the collagen diseases. We do not propose to discuss the pros and cons of this classification, but aim to present findings which are essentially confirmatory of the findings of the above authors, with certain extensions which will be noted. Certainly, the alteration in the basement membrane of glands in this disease is striking. In the normal, this structure is well demarcated in periodic acid leucofuchsin stained material as a pink to red staining membrane, postulated by Gersh and Catchpole[6] to be continuous with the ground substance of the connective tissue. Basement membrane and ground substance are assumed, on the basis of staining and solubility reactions, to consist of a colloidal aggregate of mucoprotein and mucopolysaccharide substances, and the relation between them has been discussed[6]. A characteristic reaction of this colloidal matrix appears to be its potentiality to disaggregate under certain circumstances, and a series of publications have presented evidence for the occurrence of this type of reaction in tissues following trauma, hormonal treatment, or disease[6,7,8]. In the normal material studied, granule-containing fibroblasts are observed in close relationship with the basement membranes of glands. These granules are stained red by the periodic acid-leucofuchsin method and were considered to represent precursors of the similarly staining extracellular material[6]. A direct comparison of normal and ulcerative colitis tissues shows that the latter present a picture of imperfect and fragmented or absent basement membrane of glands in particular. The staining reaction of the ground substance is fainter as a rule, and this also appears to be less homogeneous, and to contain more ice crystal artefact, indicating a higher water content. A disagrregation of the colloidal matrix with increased water solubility and "washing out" of material may be postulated as the basis of this appearance. The appearance of fibroblasts in ulcerative colitis differs from the normal in that granules seem to be largely absent from these cells in relation to the basement membrane of glands. A tentative explanation may be that in the initial stages of the disease these cells may be called upon to supply a ground substance that is being chronically lost; they eventually reach an exhausted, degranulated stage. The presence of multinucleated cells staining heavily with periodic acid-leucofuchsin is a prominent feature of ulcerative colitis material, although they are present to some extent in normals. The stainable material is not removed by buffer extraction. These cells appear to be identical with the multinucleated pleomorphic cells described by Rappaport[8] in the nasal mucosa of allergic patients.

Changes in the glandular structures of the colon involve loss of these elements, variations in their size and pattern, and changes in the character of the mucous secretion itself. The appearances noted in normal glands indicate that mucus is stored as small discrete granules; on discharge from the cell, these would be expected to swell and dissolve. Ulcerative mucosa would appear to contain an absolute deficiency of glands, and the amount of stored material often appears to be sparse. There also is a morphological difference in the appearance of the storage product, as a more homogeneous, possibly partially swollen substance. The histological appearance might be explained by supposing that there is continual release of mucin from affected glands, possibly joined with impaired synthesis. Since[6] the ground substance and basement membrane has been postulated as the route of transfer of all metabolites from blood to gland cell, such an impairment could be based on the ground substance changes observed.

It seems desirable to draw attention to one feature of these connective tissue changes the importance of which cannot be completely assessed at present. Recent work has indicated the role of the connective tissue colloids in the uptake of salts and water, based upon their properties as ionic exchange resins[7,9]. The large bowel is known to be a site from which water is normally

reabsorbed, and into which large quantities of fluids may be lost. The ability of the intestinal mucosal to absorb or retain water (and salts) appears to be intimately related to the state of aggregation of its colloids.

In this connection it may be pertinent to mention that while we have in all cases endeavoured to study patients, normal and ulcerative, who have been similarly prepared for proctoscopic biopsy, and to this extent are comparable, nevertheless, this preparation may in itself induce certain changes in the mucosa. In this connection, one may point to the rather high amount of mild inflammatory change and edema observed in colonic material in all other ways rated as essentially normal.

While the changes previously described in the mucosal membrane of the colon of patients with ulcerative colitis appear to be quite consistent, their specificity for this disease is not fully established. A careful study of inflammatory diseases of the colon, other than ulcerative colitis, and of comparable severity, is necessary to evaluate the importance and specificity of these changes.

## CONCLUSION

1. The findings previously described regarding changes in glandular basement membrane and ground substance in ulcerative colitis are essentially confirmed.
2. Parallel but smaller changes appeared in the basement membrane of the surface epithelium and mucosal blood vessels.
3. Fibroblasts related to the basement membranes of glands are granulated in the normal and degranulated in ulcerative colitis.
4. A changed pattern of mucous secretion may be found in ulcerative colitis.
5. It is hoped that these studies may throw some light on the pathogenesis of ulcerative lesions of the colon.

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## Wash wounds

Emergency treatment for compound fractures must include the process of converting a contaminated wound to a clean wound. It has been our experience that compound fracture wounds are best cleansed by using the method of Henry who advises a shower bath for the wound rather than a tub bath. After all the skin surrounding the area of the wound has been cleansed adequately with soap and water, while the wound is protected from further contamination, then the wound itself is copiously irrigated with either a saline solution spray or a spray of soap and distilled water. The object of this routine is, in the main, to remove gross contamination. *Charles K. Wier, M.D. Lower Extremity Fractures. J. Kansas M. Soc. June* 1956.

# Interpretation of the Routine Blood Count

KEITH TRUEMNER, M.D., ROCKFORD

THOSE of us in clinical laboratories of general hospitals look up frequently to see in our doorway a physician waving a laboratory report slip and saying, "What does this mean?" The following discussion is based on a series of routine blood count reports which are creations of the author's imagination rather than actual patients. Each illustrates specific points. Clinical entities, as such, will not be discussed but certain points about blood counts in general will be illustrated and certain diagnostic clews may be obtained from their interpretation.

First is shown an essentially normal adult blood count. Many clinicians have a single concept of normal with little realization of the variations induced by sex, age, and just plain individual differences. I need only remind you that such statements as hgb. 14-16 gm. and RBC.4-6 millions, are routine statements of normal values in textbooks. Time limitations prevent much discussion of these variations. I wish to comment, however, on the leucocyte variation with age since this is a frequent source of confusion among clinicians other than pediatricians.

At birth and in early infancy, leucocyte counts in excess of 12-15,000 are not unusual. The majority of these leucocytes are granulocytes. For several months after birth, the leucocyte count begins to fall toward the normal range of 5-10,000 with a decrease in per cent of granulocytes. Until the age of 4 or 5 there is a relative predominance of lymphocytes over granulocytes. In this interval, the clinician frequently raises the question of hematopoietic disease on the basis of lymphocyte percentages of 60-70% in what is a normal total WBC count. After this age, the granulocytes begin to assume their adult predominance.

Another constantly recurring "report slip-waver" is the conscientious clinician who has had a follow-up blood count on a specific patient within a matter of a few hours, and has detected what seems to him a glaring laboratory error. We must calmly assume that our technicians do work of average accuracy and proceed from there to evaluate the significance of this alleged error. The pertinent literature indicates that by the accepted routine procedures, the allowable technical error in a RBC count may be as high as 350,000 cells per cu. mm. If we take an arbitrary figure of 4,000,000, serial counts by the same individual may range from 3,650,000 to 4,350,000. It is largely for this reason that the hemotocril is being substituted for the RBC count in routine procedures in many institutions. For the leucocytes, there appears to be agreement that errors of 500-700 cells per cu. mm. are allowable. If we add such factors as diurnal variation, the effects of exercise, splenic contraction, or other sequestration mechanisms, we see that the clinical pathologist can usually "weazel out" of most accusations of inaccuracy. This does not excuse him from maintaining trained personnel and adequately calibrated equipment. Newer electronic equipment is under evaluation and may give more accurate results.

Hemoglobin determination, while technically easy to perform, is subject to wide error and variation between laboratories on the basis of difficulties in standardization. When adequate standards become available, the situation should be improved. There is a tendency to accept factory calibrated photometers as permanently accurate when this is not the case. Without going into technical details of calibration, I wish to comment on the danger of reliance upon factory calibrated glassware. A recent series of cuvettes used in an alkaline hematin method in our laboratory were found to give erroneous readings of from .5 to 1 gm. on the basis of variations in diameter and hence in length of the light path.

One variation in hemoglobin determination values between laboratories is strictly artificial and is the result of the fallacious concept of thinking of hemoglobin in terms of percentages instead of grams 100 cc. It is obvious that 100% of a 14.4 gm. standard in one laboratory is not the same as 100% in a laboratory which has used a 16 gm. standard in calibration of their procedure.

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*Presented before the General Assembly, 115th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1955.*

Another concept which arises occasionally is the distinction between relative and absolute variations in numbers of certain types of leucocytes. In a patient suspected of a viral infection such as infectious mononucleosis, a high normal leucocyte count of 10,000 assumes significance if we realize that the lymphocyte percentage of 50% indicates not only a relative lymphocytosis, but an absolute increase in the numbers of circulating lymphocytes. In a patient with a bad sore throat and a leucocyte count of 4,500 and a differential showing 50% lymphocytes and 50% granulocytes we become much more alarmed if we realize that this is an absolute granulocytopenia and only a relative lymphocytosis.

I wish to pass now to presentation of several stylized blood count reports from which some information of diagnostic import can be derived, although not necessarily indicating a specific disease entity.

A frequently encountered situation is a sudden massive blood loss of 750 cc. or more. An interesting sequence of events occurs in the peripheral blood. During the first hour or so the blood count reflects a phase of compensation in which anemia is not apparent. This is the phase of vasoconstriction and hemoconcentration. The situation may be suspected, however, by the marked rise in platelets which occurs within minutes after hemorrhage. Several hours later, anemia becomes apparent with readjustment of the intravascular fluid compartment. Granulocytosis also becomes apparent to a mild degree probably both from release by splenic contraction and bone marrow stimulation. Within a few days, regeneration should be apparent in the peripheral blood in the form of polychromatophillic and regenerative macrocytes; there may be an occasional normoblast if marrow is actively responding.

## DEHYDRATION

The next report is intended to indicate the effects of dehydration on a patient whose previous hematologic status has been normal. On the basis of leucocytes alone we might expect a mild infection. If we compare the elevation of the hemoglobin and red blood cell levels, however, we see that there is a symmetrical elevation and there is no shift to left in the granulocytes to indicate accelerated production as usually occurs in polycythemia vera. This process of dehydration may occasionally mask significant degrees of blood loss or anemia. The true situation may be detected by performing a hematocrit determination and clinical evaluation of hydration.

## HYPOCHROMIC ANEMIAS OF INFANCY

The next type is not rare in any practice, including infants. We frequently see these counts in children hospitalized for some infectious disease. The severity of hypochromic anemia usually comes as a surprise both to the clinician and the family. Most often these children are between the ages of 6 months to 2 years. Rarely can chronic blood loss be demonstrated. Hypochromic anemia and iron deficiency are difficult to produce in adults without chronic blood loss. Infants, however, who have been maintained on a largely milk diet, with multiple minor infections, readily develop an iron deficiency, hypochromic anemia. This picture is not directly related to economic status or neglect. More often it is due to improper feeding habits and the use of the bottle as a frequent "pacifier" with omission and rejection by the infant of other food elements. Although the specific therapy is replacement of utilizable iron and adequate diet with control or infection, many physicians are inclined to use blood transfusions which in our opinion are rarely required.

## CHRONIC BLOOD LOSS

We next come to another variety of hypochromic anemia. In the adult the etiology of this picture must be considered chronic blood loss until proved otherwise. The gastrointestinal and genitourinary tracts must be primarily considered with the host of etiologic possibilities represented there. In the so-called cancer age group, one cannot place too much stress on the significance of anemia *per se* as a diagnostic clew. One location, the cecum and right colon, deserves special emphasis. Review of cases of carcinoma in this location will quickly impress one with the frequency of anemia, apparently obscure, as the initial and only complaint. It should be emphasized that in this location the morphologic type of anemia is variable. We may have classical, hypochromic, microcytic RBC's but almost as frequently we find a normocytic, normochromic picture or even macrocytic cell pictures. The etiology frequently is more complicated than simple blood loss and involves less well understood factors of changes in intestinal bacterial flora and absorption of hematopoietic factors.

Likewise the anemia of chronic renal disease is not always on the basis of continued, low grade, blood loss but may be partially the result of direct inhibitory effect either on myeloid function or cell release mechanisms in the presence of chronic azotemia.

We cannot spend much time discussing the megaloblastic anemias. You all recognize in this report the classical features of deficiency of erythrocyte maturing factor; macrocytic normochromic anemia, and the morphologic alterations in the red blood cell, leucopenia with the more recently emphasized morphologic changes in the granulocytes, and varying degrees of thrombocytopenia. We all would feel fairly confident in suggesting pernicious anemia on the particular blood count showing severe relapse. Unfortunately this picture is extremely rare in these days of polypharmacy when most patients present themselves having taken varying amounts of potent "vitamin pills." The usual picture is blurred both in the peripheral blood and bone marrow by partial treatment effects. The recent use of radioactive vitamin $B_{12}$ is aiding in the diagnosis of this group of patients. It should also be emphasized that in addition to the true megaloblastic anemias of addisonian type, tapeworm infestation, and sprue causation, many macronormoblastic pictures are seen in severe hepatic and gastrointestinal diseases. Accurate diagnosis of true pernicious anemia requires careful evaluation of the hematologic picture (blood and marrow) clinical findings, gastric acidity, and treatment response.

The next picture is not too frequently encountered in the average small to medium size general hospital but deserves comment because it may occasionally suggest an early myelogenous leukemia as it did to several internists at a recent meeting where we called for diagnoses from the floor. The leucocytosis will moderate left shift and the erythroblastosis are compatible with the bone marrow stimulation occurring in the hemolytic anemias. Of course, here we have credited the technician with recognizing the classical spherocytic microcytes on the routine count which helps in the diagnosis.

The next slide is included because of the frequency with which it is seen and the obscurity of pathogenesis. The occurrence of mild degrees of normocytic normochromic anemia in the woman at or near the menopausal age is apparent, especially to those dealing with female donors in blood banks. One usually investigates diet, menstrual history, endocrine status, and even performs bone marrow examination without helpful results. Shotgun hematinic therapy is of inconsistent help. I am not too clear as to the ultimate course of these patients. Fortunately the degree of anemia is rarely dramatic. They are a most damaging group of patients to the clinical pathologist's reputation as a hematologic diagnostician.

There are two groups of cytopenic states that should be commented on: The first are the cytopenias developing from bone marrow suppression either on a toxic basis or the so-called idiopathic varieties. While it is true that one element or the other of the peripheral blood may be disproportionately involved, there usually is a rather obvious effect on all cell elements. The peripheral manifestations may be predominately anemia, leucopenia, or thrombocytopenia. The peripheral blood picture usually is a quiet disappearance of cell elements unaccompained by immaturity or other evidence of regenerative activity until remission occurs.

The second category is the group usually called myelophthisic. Included here are the conditions of so-called agnogenetic myeloid metaplasia, neoplastic involvement of marrow by such entities as carcinoma, Hodgkin's disease, or lymphoblastoma. Here, because the marrow involvement is not total, we find evidence of peripheral immaturity representing compensatory activity of uninvolved marrow or release of cells from extramedullary sites of hematopoiesis. The immaturity of the leucocytes may be sufficient to suggest leukemia in some instances. Leucocytosis may actually occur producing so-called leukemoid reaction.

In conclusion, I wish to repeat my initial remarks that this rather unscholarly and general presentation has been an attempt to indicate some of the more common problems and certain diagnostic clews which the clinical pathologist encounters in the interpretation of routine blood counts. We have dealt with broad categories of peripheral blood findings much in the manner of a baseball coach playing the percentages of the game. The conclusions reached must always be placed in proper relationship to other laboratory evidence and the clinical evaluation of the patient.

# CASE REPORTS

# Unusual Sequela of Ringworm of the Scalp

JERRY C. LEVIN, M.D., AND ALFRED B. FALK, M.D., CHICAGO

Ulceration complicating tinea capitis in children occurs infrequently. This is a report of a patient having an apparently mild fungous infection of the scalp, in whom there suddenly developed a kerion which quickly became a severe ulcer simulating a Meleney type lesion. Laymon[1] mentions erosions and ulcerations occurring with tinea capitis but a review of the available reports of the past 20 years, including our cases at The Children's Memorial Hospital for the past 10 years, shows no similar occurrence.

J. P., a white male aged 9 years 9 months was well until November 1954. At that time he developed a patch of alopecia the size of a 25 cent piece in the occipital area. Examination of this patient and his two brothers under the Wood's light demonstrated the presence of marked fluorescence of the affected hairs, findings compatible with the diagnosis of a fungous infection.

Treatment with a fungicidal ointment, Hyanilid,® was initiated along with the wearing of a stocking cap. Four months later the patient developed a kerion, a mild purulent secondary infection at the site affected by the fungous infection. The above ointment had been used continuously since the first examination. The kerion[2] was not extensive but fungicidal medication was stopped. The local use of hot® compresses was instituted along with Gantrisin orally. Within a few days an ulcer three centimeters in diameter destroyed the site of the previous fungous involvement (Figure 1). An undermining border extended about the entire periphery of the ulcer, the base of which was the periosteum of the skull. Surgical debridement and vioform paste locally, along with orally administered antibiotics, resulted in complete healing of the ulcerated area within a month's time.

Laboratory studies including Kahn test, blood counts, and fractionation of blood proteins were within normal limits. Material removed from the ulcer and cultured proved the absence of fungi and the presence of beta hemolytic staphylococci.

A culture of affected hairs from one of the patient's brothers demonstrated the presence of Microsporon audouini.

## COMMENT

Miller, et al,[3] cultured Microsporon audouini from 96.6 per cent of his patients in a series of

*From the Departments of Dermatology, The Children's Memorial Hospital and the University of Illinois, College of Medicine.*

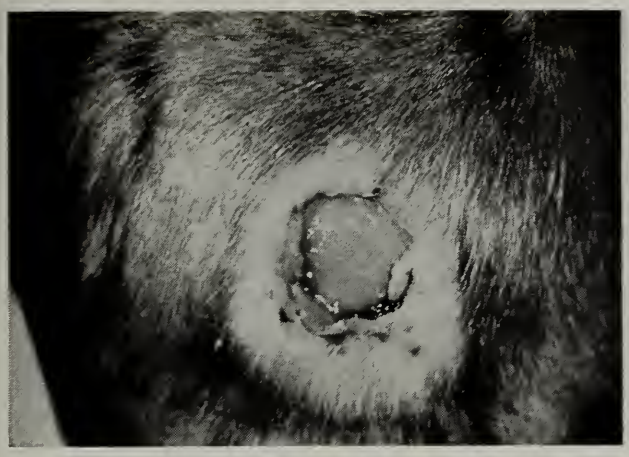


Figure 1. Ulcer of scalp.



Figure 2. Healed ulcer.

928 cases of ringworm infection of the scalp. Warner and Grove[4] in a similar study with 40 patients was able to demonstrate the fungus in only 28 of these. All of the 40 individuals in the latter study had fluorescence of the affected sites under the Wood's light. Severe secondary infection is an obstacle to the demonstration of the fungus.

In our patient, the diagnosis was established by the physical findings, positive evidence under the Wood's light, and demonstrating exposure to Microsporon audouini. The general health of this child was excellent. Why this infection was so severe is debatable. Once the kerion appeared X-ray treatment was excluded as a modality of aid. Possibly early use of radiation therapy could have prevented the series of events in this child. Antibiotic therapy undoubtedly served to prevent further progress of the ulcer (Figure 2).


## SUMMARY

A case of ringworm infection of the scalp in a child is presented and the unusual extent of ulceration demonstrated. The probable cause of this complication was his lack of resistance to the virulent secondary bacterial infection.



25 E. Washington St.



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2. MacKee, G. M., and Cipollaro, A. C.: Skin Diseases in Children, Paul B. Hoeber, Inc. p. 49, 1947.
3. Miller, J. L., et al.: Local Treatment of Tinea Capitis, J.A.M.A., 132:67, 1956.
4. Warner, M. P., and Grove, F. E.: A Study of Forty Cases of Ringworm of the Scalp, J. Pediat., 43:267, 1953.


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## Night calls

It is important that physicians not acquire and carry over from their residency training experience certain attitudes toward practice which may later cause the public to be critical of the medical profession. This refers to the charge that modern physicians are unwilling to answer night calls and otherwise hold themselves available for service outside normal duty hours. This circumstance has necessitated vigorous efforts on the part of physicians to improve their public relations. Since many of the practicing physicians of today served during the period of war in military hospitals, they became accustomed to the practice of leaving their hospital responsibilities in the hands of an officer of the day at the end of the day. This was partly fostered by the transportation shortage and the existence of motor pools. As larger numbers of military physicians acquired families, there was more reluctance to spend long hours in the hospital at night. *John C. Nunemaker, M.D. The Professional Responsibilities of a Physician. Veterans Administration, June 27,* 1956.

# Anaphylactic Reaction of Penicillin — V

Werner Fliesser, M.D., and Charles A. Ramey, M.D., Hoopeston

SENSITIVITY to all forms of penicillin has been described. Occurring as anaphylactic or urticarial reaction it has been observed following parenteral and, to a lesser degree, oral administration.

In the following case a severe anaphylactic reaction developed after ingestion of one tablet of penicillin V (125 mg.).

C.L.F. a 54 year old male factory superintendent, was given penicillin V tablets for treatment of an upper respiratory infection. He was known to be sensitive to parenteral procaine penicillin G and had developed angioneurotic edema of the face and generalized urticaria in March 1955, three days following administration of procaine penicillin G intramuscularly.

On January 11th this man took one tablet of penicillin V (125 mg.). One half hour later he noticed generalized itching and formation of wheals. Both increased in size and intensity, and during the next fifteen minutes his hands swelled and he experienced difficulty in breathing. He stated that his throat was swelling shut. A few minutes later he was unable to talk above a whisper, was breathing with a loud stridor and became unconscious.

At this moment he was seen by one of us (C.A.R.) at the factory. He presented the picture of severe cardiovascular collapse. A radial pulse was unobtainable, the blood pressure was 60/44, the breathing was severely labored, shallow and irregular. His face was edematous and pale. He was immediately given 0.5 cc. of 1:1000 solution of epinephrine intravenously. While this was administered slowly he regained consciousness and the pulse became palpable. At the same time oxygen became available. Ten minutes later another dose of 0.5 cc. epinephrine was given subcutaneously, followed by 100 mg. cortisone and 1 cc. of 1:500 suspension of epinephrine in oil intramuscularly. The blood pressure had risen to 82/46 and he now was alert and communicative, stating that he felt well except for generalized itching. The facial edema and general urticaria were still noticeable although diminished. Thirty minutes later his blood pressure was 122/78 and he was returned to his home with a prescription for prednisolone 5 mg. tablets to be taken every six hours.

It was hoped that with the oral administration of penicillin V a known sensivity to other penicillin salts may be circumvented. It appears now, however, that passive transfer tests performed by Woodin[1] indicate that cross reactions to penicillin V should be expected in persons who had previously experienced sensivity reactions to other penicillin salts.

217 S. Bank St.

[1]Woodin, W. G. Personal communication.

# EDITORIALS

## Nickel dermatitis

Contact dermatitis due to nickel is becoming more prevalent. Fisher and Shapiro[1] saw 198 patients over a five year period with dermatitis of this origin. Calnan and Wells[2] reported that the condition now is the most common type of sensitivity dermatitis encountered in routine dermatological practice. The results of patch tests in their clinic over the past three years are as follows:

| | Total Positives | Nickel Positives |
|---|---|---|
| 1953 | 478 | 131 |
| 1954 | 412 | 198 |
| 1955 | 420 | 180 |

The increased incidence may be explained by this claim of a leading nickel manufacturer: "Nickel is with you and does things for you from the time you get up in the morning until you go to sleep at night."

This statement is fairly accurate as contact with the metal occurs through the fasteners, clasps, clips, and buckles on garters, girdles, earrings, brassieres, zippers, hair grips, brooches, spectacles, watches, suspenders, and bracelets. Nickel is used also in thimbles, knitting needles, metal chairs, certain coins, handles of car doors, baby carriages, umbrellas, refrigerators, and handbags.

The primary eruption develops over the area where the metal touches. The skin of the thighs, for example, is involved from contact with the fasteners on garters; the ear lobes, from earrings; and the chest from brassiere clips or necklaces. The typical eruption consists of small papules and vesicles with signs of excoriation and friction. Less frequently, the lesion is acutely exudative and sometimes thickened and lichenified. On the ear lobes, it is exudative and crusted.

The secondary sites are unrelated to direct contact with the metal. The outbreak spreads to the elbow flexures, eyelids, sides of neck, and inner thighs. Occasionally it becomes generalized. It consists of scattered papules and papulovesicles on a background of erythema. Pruritus co-exists. The cause often escapes detection because the patient waits until the secondary rash appears.

A careful history is needed to uncover the sequence of events leading to a suspicion of contact dermatitis. Fisher and Shapiro found patch testing with a five per cent nickel sulfate solution an adequate diagnostic method. Patch testing with nickel coins is reliable also, provided the coins actually contain nickel. This metal was replaced temporarily during World War II with silver and manganese. It is important to use a coin that was manufactured prior to that time or after 1945. The coin is fastened to the skin and left in place for 48 hours. Redness, swelling, itching, and small blisters indicate a positive result.

Since it is so difficult to avoid nickel, each patient must solve his own problem. Earrings, for example, can be painted with a clear nail

1. Fisher, Alexander A. and Shapiro, Alfred: J.A.M.A. 161: 717, 1956.
2. Calnan, C. D. and Wells, G. C.: Brit. M.J. 4978: 1265 (June 2) 1956.

lacquer; or the part touching the skin may be covered with adhesive, cellophane, fabric, plastic, or other protective. Dusting with talcum powder before putting on the earrings will protect for several hours. The condition is worse in the summertime because sweating dissolves the metal more readily.

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## Special meeting of the house of delegates

On Sunday, August 19, a special meeting of the House of Delegates of the Illinois State Medical Society, was held at the Hotel Sherman, Chicago. This session was called to consider Public Law No. 569, passed by the 84th Congress and commonly referred to as the Dependents' Medical Care Act. There were 140 delegates representing 65 component county medical societies.

As the first order of business, the President, Dr. F. Lee Stone, called upon Dr. Edwin S. Hamilton to give a report on Public Law No. 569, and the work of the A. M. A. committee which is working with the Department of Defense on plans for putting the Act into operation.

Dr. Hamilton, as chairman of the A. M. A. Task Force Committee on Dependents' Medical Care, had met with representatives of the D. O. D. on several occasions and carefully reviewed several drafts of the program. Only three days prior to this meeting, Draft No. 7 had been released, and copies were available for those desiring to see the few minor changes from Draft No. 6 which had previously been mailed to all delegates.

Dr. Hamilton also pointed up the fact that if the Society chose not to participate in the program, the D. O. D. was authorized by Law to set up a plan of its own for the State.

A panel was on hand to answer questions from the Delegates. Dr. Percy E. Hopkins, as Chairman of the Committee on Medical Service and Public Relations, was moderator of the panel, which was composed of the members of his committee, Doctors Piszczek, Sweeney, Coleman and Hamilton; John W. Neal, the Society's counsel; representatives of the Illinois Medical Service and the Northern Illinois Blue Shield Plan operating from Rockford, a representative of the commercial insurance companies and Mr. Joseph Stetler, head of the A. M. A.'s Law Department.

Many questions were asked, and the moderator referred them to members of his panel, for the answers. It was stated that this care applies only to dependents of those in the uniformed services, and has nothing at all to do with the Veterans Administration and its services. After the discussion period ended, Dr. Stone said that there were three things to be decided at the meeting. They were:

1. Does the Illinois State Medical Society desire to participate in the operation of the Dependents' Medical Care Act?

2. Does the Society desire to act as the fiscal agent for its operation in Illinois, or do the delegates prefer to select perhaps a Blue Shield Plan operating in Illinois, or a commercial insurance company to act in this capacity?

3. Matters relative to the establishment of fee schedules to cover the many services to be rendered to those covered by the act in Illinois.

Dr. Hopkins was asked to poll the representatives of Blue Shield plans and the commercial insurance representative as to whether their respective organizations would be willing to act as fiscal agent in carrying out the provisions of the law. These representatives all gave assurance of their willingness to cooperate in the carrying out of the provisions of the Act.

The first motion was that it be the consensus of the House of Delegates that the Illinois State Medical Society participate in this program. The motion was duly seconded and passed.

The second motion, was "that we have an Illinois Blue Shield Plan act as the fiscal agent." This motion was carried.

It was then moved that the Executive Committee of the Council "be instructed to enter into any agreement necessary to implement this action." The motion carried.

A Delegate then asked, "if the policy-making group of the Blue Shield Plan selected does not desire to enter into this kind of agreement, then what shall we do?"

A motion was made and duly seconded, "that if this is not accepted by the Blue Shield Plan, the matter be left to the discretion of the Council to find another fiscal agent". The motion carried.

There was considerable discussion relative to the matter of fees for services to be rendered to the dependents, as prescribed in the law. After this discussion, it was moved that a committee from the Council be designated to go over the entire list of services for which fees are to be charged, then report its recommendations to the Council for final action. A second was received and the motion was carried.

It must be remembered that the medical profession had for many years endeavored to have the government provide civilian medical care for dependents of persons in the uniformed services. Now that there is a federal law enacted to provide such care, we physicians must do everything we can to make the program work to the satisfaction of uniformed service personnel, the medical profession and the federal government.

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## Legislative — Public Relations meeting

The annual Public Relations Institute of the American Medical Association was held at the Drake Hotel, Chicago, on August 29-30, 1956. The Illinois State Medical Society cancelled its P.R. dinner meeting, usually held during the annual meeting in May, so the Council approved the recommendation of the Chairman of the Committee on Medical Service and Public Relations, that the component county societies having a P.R. chairman be asked to send the chairman to this meeting with expenses paid by the society.

A dinner meeting was held on the evening of the 29th at the Hotel Sherman for the P.R. chairman from Illinois, with an evening program, and with time for discussion of some problems in that field.

With the assistance of the A.M.A.'s legal staff, an interesting afternoon session for county society Legislative chairmen was arranged, and also conducted at the Hotel Sherman 2:00 until 5:30. Approximately 50 were present for the afternoon meeting as well as the dinner and after dinner talks. Harlan English presided at this afternoon meeting, and he first discussed the subject "The Big Picture" (Report on National Legislation). Mr. R. G. Van Buskirk, secretary, A.M.A. Committee on Legislation, had a "preview" on what to expect in the 85th Congress.

Mr. Walter L. Oblinger, associate counsel for the I.S.M.S., talked on legislation at the state level, while Mr. John W. Neal, general counsel, talked on "Licensure and Regulation of the Healing Professions." Percy E. Hopkins, chairman of the Committee on Medical Service and Public Relations discussed Blue Shield enabling legislation. The proposed revision of the Coroner's Act was discussed by Edwin F. Hirsch, and Frederick W. Slobe talked on the proposed revision of the Workmen's Compensation Law in Illinois.

Thomas Alphin, Director of the A.M.A.'s Washington Bureau told of the work of his group at the nation's Capitol and what he desired from those at the state level. With all participants acting as panelists, an hour-long question and answer period followed.

Dr. Hopkins presided at the evening meeting following the dinner, and the first speaker was Mr. George E. Hall, staff associate, A.M.A. Law Department. His subject was, "Coroner Versus Medical Examiner Systems in the United States." The last speaker was John L. Bach, Director of Press Relations, A.M.A., who presented an interesting paper entitled. "Who is Going to Bell the Cat?" Although the subject would no doubt cause some who did not hear it, to wonder what he was talking about. Mr. Bach gave an excellent discussion of public relations problems affecting the medical profession. A discussion period followed the evening program and those who participated received worthwhile information.

These programs were arranged by Mr. Edward A. Uzemack, P.R. Director for the Illinois State Medical Society, and he deserves much credit for the success of the meetings. The two groups attended the A.M.A.'s P.R. meeting the following day, where many excellent talks were presented.

Dr. Hopkins and his Committee on Medical Service and Public Relations also deserve much credit for the afternoon and evening meetings held at the Hotel Sherman for Illinois chairmen from the two committee groups.



Roland R. Cross, Director, Illinois Department of Public Health, in his new office.




Ruth E. Church, Chief, Division of Communicable Disease Control, and Mr. Albert Hampsmier, shown in the vaccine storage room.

## New offices for the Illinois Department of Public Health

Dr. Roland R. Cross, Director, Illinois Department of Public Health, has worked diligently in his many duties over a period of 16 years under handicaps. This summer, the fine new office building erected by the State of Illinois was completed. Recently the State Health Department moved its entire staff and equipment into the new building, occupying all the fifth and part of the sixth floor. It was recently the privilege of the officers of the Illinois State Medical Society to inspect these fine quarters, and we asked for a statement and some pictures which we believe will be of interest to the medical profession of the state.

Dr. Cross' long tenure probably establishes a record for all code departments of the state and certainly for the Department of Public Health. No previous director held that position for more than eight years and none served under more than one governor. Dr. Cross has established another record by serving under four governors, two Republicans and two Democrats.

The medical profession in Illinois, through cordial relationships and close cooperation with Dr. Cross and his staff, has had confirmed its belief that the cause of better health is best served when the practicing physician and the public health profession work side by side. These years have also demonstrated that the continuing philosophy and principles of an able administrator result in program maturity and effectiveness.

The public health program in Illinois reflects such maturity and effectiveness. Over the years the contributions and services of the Department of Public Health have been expanded, intensified and improved. A brief review of a few examples will suggest the quality and vigor of the department's program since Dr. Cross' initial appointment on October 19, 1940.

1. Communicable diseases generally are far less prevalent than ever before in Illinois and the trend is downward. No case of smallpox has been reported in the state since 1947, while diphtheria and typhoid fever are close to the vanishing point.

2. The care and treatment of tuberculosis patients, a significant control measure, was entered upon for the first time by the state in the late 40s. The construction of two state tuberculosis sanatoria, with a total of 585 beds, and their subsequent operation by the department, has contributed substantially to the reduction in mortality from tuberculosis. Another major activity in the control of tuberculosis has been the casefinding program. Mobile units for taking free x-rays of the chest have operated throughout the state since 1946. More than 300,000 x-rays are taken annually by these units. Tuberculosis deaths have declined from 40 per 100,000 persons in 1945 to 9.2 in 1955. This is a reduction of about 75 percent in 10 years.

3. The community hospital construction program was begun in 1947 with a comprehensive survey of the hospital situation in Illinois to



View of the general offices of the Bureau of Communicable Disease Control.



Mr. Baxter K. Richards, Deputy Director, Division of General Administration, Illinois Department of Public Health, in his new office.

determine areas of greatest need. The department has worked closely with communities in fostering construction where really needed. Since 1947, 71 projects with an aggregate of 5,300 beds have been authorized at an overall cost of almost $100,000,000. Of these, 48 are now in operation and located in communities which previously had no hospital facilities or only obsolete and inadequate facilities. The program will make adequate hospital services available within 30 miles of any residence, or the equivalent driving time.

4. Because the greatest single cause of death among babies is being born too soon, the program for the care of premature babies was started in 1943. The case load for the first year was 50. About 1,000 babies are now cared for annually in this program.

5. The mushroom growth of nursing homes in Illinois resulted in the enactment of legislation in 1945 requiring licensure of these homes to alleviate undesirable conditions. Through its inspectional and licensing program, the department has been able to improve operational standards of some 630 licensed nursing homes which care for about 24,000 people.

6. The licensing of trailer coach parks, in accordance with a law enacted in 1953, has resulted in substantially improved sanitation and safety in the nearly 600 trailer coach parks which provide living quarters for some 40,000 people.

7. The licensing of hospitals and the consultation service provided to hospitals is promoting the improvement and maintenance of high standards of operation in some 300 Illinois hospitals. Comprehensive regulations were approved by a Hospital Licensing Board of physicians, representatives of hospital administration, and members of governing boards.

8. Since the enactment of enabling legislation in 1943, 27 counties in Illinois, with help and encouragement from the department, have established full-time health departments. With the full-time municipal and district health departments, these provide two-thirds of the people of Illinois with full-time services on a home-rule basis.

9. Detailed diagnostic service for some 4,000 patients annually is provided by 29 cancer diagnostic clinics throughout the State. These clinics are financed in varying amounts by the Department of Public Health and serve the practicing physician in detecting many cases of cancer and potential cancer in the early curable stage.

10. The Department spearheaded an all-out fight on poliomyelitis by the purchase and free distribution to physicians of more than 4,000,000 doses of polio vaccine which was paid for from a state appropriation of $1,000,000 and a Federal allotment of $1,887,000.

11. The department carries on a two-pronged program for the control and prevention of heart disease. This includes an attack on rheumatic fever, a prolific source of heart disease, and the operation of two clinics for the early detection of heart disease. A penicillin preparation to prevent recurrence of rheumatic fever is distributed

free by the department to physicians in cooperating counties and county medical societies. Some 1,700 children are now being treated.

12. An extensive laboratory service is maintained which tests about 1,000,000 specimens per year for various communicable diseases and for analyses of water and milk.

13. Dental x-ray surveys of children throughout the State are conducted for detecting tooth decay and for motivating them and their parents to seek early dental care. Approximately 50,000 children are x-rayed annually.

14. Fluoridation of public water supplies has been encouraged since this method of preventing tooth decay was scientifically proven advantageous. Approximately 90 communities in Illinois are now providing fluoridated water to almost 5,000,000 persons.

15. Three narcotics outpatient clinics have been operated in Chicago through funds made available by the department. About 250 narcotics addicts annually are given medical counseling to keep them away from narcotics, to help them get and hold jobs, and to help them adjust to normal community life and behavior.

16. A medical residency in public health has been established for qualifying physicians through a joint program of the Department of Public Health and accredited local health departments. This is an educational program of two years duration accredited by the American Board of Preventive Medicine and the Council on Medical Education and Hospitals of the American Medical Association. Cooperating in this program to interest and qualify young physicians for a career in public health is the Illinois State Medical Society, the University of Illinois, and the Illinois Statewide Public Health Committee.

17. A recent and long needed improvement is the acquisition of new and commodious office space for the department. The department now occupies all of the 5th floor and a part of the 6th floor of the modern State Office Building in Springfield.

These are but a few of the programs and accomplishments of the Department of Public Health, which are contributing effectively to the health of the people of the state. Prevailing health conditions in Illinois today are better than at any previous time in the state's history. Death rates from preventable causes are lower than ever before while the birth rate is unusually high, indicating a vigorous, healthy population.

Many additional programs could be cited in the fields of school health, maternal and child health, adult health, environmental sanitation, nutrition, and others. This review is sufficient, however, to reflect the great strides that the public health program has made under the able leadership of Dr. Cross. This happy state of health affairs in Illinois recalls to mind the words of George Eliot: "The reward of one duty done is the power to fulfill another."

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## Health insurance coverage at an all-time high

A recent release from the American Medical Association gave some interesting information on the present status of hospital and medical care insurance. Benefit payments to help people pay hospital and medical care bills are running 20 percent higher than a year ago, according to an announcement by the Health Insurance Council. This information was released following the 10th annual survey of the extent of voluntary health insurance coverage in the United States.

The Council estimates that as of July 31, 1956, some 110 million persons were covered by hospital insurance; 94 million had surgical protection, and 58 million had regular medical expense coverage. In addition to these protective measures, seven million were insured against major hospital and medical expenses. The entire survey brings together Blue Shield and Blue Cross figures, as well as those of independent plans, and plans underwritten by insurance companies.

Some interesting highlights of the survey as of the end of 1955 were released. The number of persons insured against hospital expenses increased by 6.1 percent; surgical insurance was up 7 percent; regular medical expense insurance gained 17.5 percent, while major hospital and medical expense insurance was up 134.5 percent.

Benefits for hospital expense held the top spot in America's health insurance program—59,645,000 persons held policies from insurance

companies 50,726,000 enrolled by Blue Cross—Blue Shield, and 4,530,000 were covered by miscellaneous plans. It is quite obvious that there is an increasing public awareness of the cost of catastrophic illness which was largely responsible for the sharp rise in the number of people covered by major hospital and medical expense insurance. More than 90 percent of the 5,241,000 persons covered at the end of 1955 had protection through their place of employment while the remainder of the group were insured through individual and family plans.

Protection to help meet the expense of surgical care was provided by private insurance companies to 56,645,000 persons; by Blue Shield—Blue Cross plans to 39,165,000 and by other types of plans to 4,340,000.

The Health Insurance Council is a federation of the leading insurance associations, and its report will be available in pamphlet form later this year.

## Medicine on postage stamps

Among the postage stamps issued in recent months and of interest to collectors of stamps with medical subjects were the following:

Columbia—A 5c stamp bearing portraits of Jean Henri Dunant, founder of the International Red Cross, and Santiago Samper Brush, founder of the Columbia Red Cross in Bogota in 1902.

Cuba—A 1c postal stamp tax (on November 1) to help in anti-tuberculosis work.

Czechoslovakia—Stamps showing views of four spas—Karlsbad, Marienbad, Piestany and High Tatra.

Dominican Republic—A 1c antituberculosis postal stamp tax, with the lettering B.C.G.

Guatemala—A 9-value set for the Red Cross. Six different designs include an ambulance, nurse, hospital and Red Cross.

Jugoslavia—A 2d postal tax stamp for the benefit of the Red Cross, required on all letters, May 6 to 12.

New Zealand—The 1956 issue of Health Stamps consists of three denominations with surcharges of 1/2d or 1d being used to finance children's health camps. The design shows one child handing an apple to another child—on the theory, perhaps, that an apple a day keeps the doctor away?

Philippines—5c and 20c stamps commemorating the 50th anniversary of the Red Cross, picturing a nurse comforting victims of a disaster.

Russia—Two stamps for the Red Cross Society of Russia which was created during the Crimean War under the leadership of the Russian surgeon, N. I. Pirogoff. A 40k shows pupils being taught principles of sanitation; a 1 ruble shows a nurse and workroom in a textile family. A Russian inscription says: "Safeguard the working masses' health."

Turkey—A 40k stamp plus 10k stamp picturing the Erenkoy Sanatorium; a 25k stamp for the anti-alcoholic movement; a 60k stamp (in November) for the 75th anniversary of the founding of the Medical Faculty of Anatolia.

Eleven postal authorities in 1955 issued 34 Red Cross stamps, according to the Red Cross World. Since 1889, when the first Red Cross stamp was issued, 1,420 Red Cross varieties have been put out by 127 postal administrations. France leads with 172 stamps. Other important issuers are: Portugal, 166; Spain, 147; Turkey, 101; British commonwealth countries, 90, and Finland, 82. China and Netherlands New Guinea issued their first Red Cross stamps last year.

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# MEDICAL ECONOMICS

John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.

# Private Practice

JOHN R. WOLFF, MD., CHICAGO

PREVIOUS articles in this Medical Economics section have discussed some of the opportunities available to the young medical school graduate in various fields. Anesthesiology, pathology, public health, obstetrics, general practice, and others have been presented. But what about private practice per se? What are the opportunities? What is the best method to establish and mold a practice? What are the rewards compared to other fields?

Fifty years ago the entrance into the actual practice of medicine was a relatively simple, painless economic phenomenon. Young Doc, armed with his medical school diploma and his state license, merely found a community to his liking, set up an office, hung out his shingle, opened the door, and started in business. At first he did not fare too well. But being a youth of twenty-one or twenty-two, he could stand hunger. Yet he soon found himself getting too busy to give his growing moustache its necessary care. He began to work longer hours, to eat better, save a little money, and become a part of his community. Soon he became "Old Doc," cursed at by a few, loved by many, and respected by all. Practically every embryonic physician followed this pattern.

But what about today's young graduate? Well, by the time he is ready to make the important decision concerning his medical economic life, he cannot truly be called a "young Doc." His years of undergraduate work, medical school, internship, residency training and military service bring him up to the thirties in age. By this time, he has usually acquired a wife and at least two children.

Is today's "young Doc" prepared to enter private practice? Educationally and medical speaking, he certainly is much better equipped than was his father. But this is not so from the psychological viewpoint. The temptations and illusory security of other opportune medical situations are too great. The trap of fame and fortune by association is subtle and strong. After all his years of apparent economic security wrought by hospital and military salaries, a hard working, ever-loving wife and some understanding relatives, is he ready to meet the challenge of starting on his own? His present standard of living, plus the natural desires of his family, tend to lead him in other directions.

With so many paths available to "young Doc," he must be cautious not to be tempted by the smoothly paved road under his feet, but he must study the road maps and observe the terrain in the distance. This proximate decision as to his future medical life is a most important one. It should be made only after careful thought and an honest search into his likes and dislikes, am-

bitions, needs, and, of course, with a long view toward the future.

By this time one has made the decision whether to engage in research, teaching, the pre-clinical sciences or some adjuvant phase of medicine, such as the insurance field, medical organizational work or the like, on a full time basis. These words are not intended for such individuals, but rather for the man or woman who wishes to be a doctor Catering to the ills of mankind. Although he may and often does devote a portion of his time to other activities, his major medical economic action will be directed toward developing his practice.

The first trap awaiting him is the desire to become associated with an established individual. In the old days an assistantship to a renowned man was a sought after prize, so that one could obtain training and clinical experience with a master. Today's residency training has obilterated the necessity for this academic association. Today this desire stems from the search for financial security. A steady income, the hope that it will increase, the entrance into an existing going practice, and the possibility that some day the beginner will succeed the old-timer are strong attractions. Anyone who has surveyed the scene for a number of years realizes the futility of such a venture. The successes are too few, the failures are too many. The "young Doc" immediately becomes an assistant. He may be called an "associate" or "partner," but he still remains an assistant. If he has a will of his own and possesses a normal desire to stand on his own feet, the association may last from two to five years at the most. The divorce is usually a painful one to both members and leads to many tragedies, usually to the detriment of the younger man. Should the association persist, the junior man's personality invariably deteriorates to that of a pipsqueak. You, of course, may prefer this anonymity of medical existence. So be it. But if you do have red blood in your veins, investigate all the partnerships and such associations before starting yours. Don't just glimpse at the rare successful ones. Study the failures and study the personalities of the men who remain lifelong assistants.

Another trap is that of group practice. This is an extremely appealing situation to the young specialist. He sees an opportunity to cash in on his residency training at once. He can enter an established group. Medical activity awaits him. A pleasant association with other physicians is intriguing and, of course, a steady income will be his. He also sees a rosy future with a chance to become a junior member of the group, later a stockholder, and eventually, an executive position in his old age. Such opportunities do exist, but in the vast majority of cases, he just has a job. As such, he is at the mercy of his employers. Everything is fine until the day comes when his wife has a heart to heart talk with him and points out the disparity between his value to the group and his relative compensation. The end soon arrives. Too often the "olding" youngster is out on his own again. Before entering into any type of group practice, legal advice is essential. And so is a thorough discussion with all members of the group, both present and past. Unless you can find utopian individuals in a utopian group, beware!

What about partnerships? Many successful ones exist. Analysis of such associations shows that their success is due to two or more successful individuals joining together. They invariably have busy established practices. The association is most often made so that each man can conserve leisure time without neglecting or losing patients. The pooling of overhead expenses is another important value. In one way, a partnership assures an excellence of care to patients in the absence of a selected physician. But such a partnership is for the older busy individual. Two youngsters may start out this way, but one must remember that two times zero still equals one times zero.

Today it seems that every physician finds some kind of part time employment to help him while his practice is developing. Public health positions, industrial medicine, teaching, research, and various health agencies offer these opportunities. They certainly are necesary in answering the need for immediate income. The only danger is in losing the long view and letting these positions dominate one's thinking. Private practice must always come first. As this develops, jobs should be dropped. Otherwise the physician will only be half his own master.

What then about private practice? The great economic and psychological values of private practice lie in its true security. Although no physician owns patients or in a sense can say

that such and such a person is "his" patient, it is true that when an individual becomes ill, he immediately thinks of one doctor above all others. This doctor is his physician and he will call him for advice. The general practitioner as a family doctor sees this every day. Such a relationship is the foundation of his practice. By practicing good medicine and giving service to those who seek him, he will build up a group of patients who always think of him as their doctor. When this group enlarges to a goodly number, his security is ascertained. An investment counselor might call this "true diversification." While some patients may find fault or lose confidence and change doctors, the majority tend to stick, and new patients become attracted too. The only way to develop such a practice is to go to work and do it. Opening an office, getting known to one and all as a physician, and giving excellent service when called is the only method. Yes, it is a slow process, but eventual success is there. A quicker road today is to go to a community needing a doctor. Such a choice should be tempered by the physician's wants and needs in life outside of medicine. His family's desires should also be given equal consideration.

Where does the young specialist fit into this? If he is a super-specialist, such as a cardiac surgeon, chest surgeon, neurosurgeon or roentgenologist, that is, one trained and experienced in a detailed technical branch of medicine, he must perforce become a doctor's doctor. His practice will be referrals from other physicians. His opportunities are presented by physician-hospital associations, medical organizations and the like. The large teaching centers are for him.

But what about the pediatrician, obstetrician-gynecologist, internist, general surgeon, and so on? If he prefers, he can act as his superspecialist friend and await referrals from doctors. However, this preference shows somewhat immature wishful thinking. Some communities may be in actual need of a surgeon or pediatrician. But today such specialists are usually not too rare in any population center. With the ease of travel that we now have, the well known oldtimer is too readily available. It has been said that the general surgeon is a general practitioner who operates, the internist is a general practitioner who does not operate, the pediatrician a general practitioner for babies, and the obstetrician-gynecologist is a general practitioner for women. Such remarks bear more truth than jest.

The young surgeon who feels that he has the answer to all surgical problems falls into a serious trap by hoping to await doctor referrals and just operate. His referring friends may have a change of heart, they may revert to older surgeons because of confidence from previous associations, or they may become attracted to other young surgeons. The security of depending on such contacts is too tenuous and dangerous. For eventual independence, the young surgeon must develop his own patients. These people will think of him as a doctor who caters to their everyday health problems, refers them to specialist friends as needed, and who undertakes their surgery when the demand arises. This same philosophy of practice applies to the other type specialists as well.

You may feel that this suggested method of developing one's own practice regardless of type of specialty is not necessary or even desirable. One can mention many economically successful physicians, especially in the larger centers, who did not follow this pattern. That is true. Many first made their reputation through research and teaching. Then by means of a hospital appointment they went right to the top. But how many have this opportunity? And can't you think of a few who have suddenly been dropped from their lucrative post for some reason or other? Then what? And can't you think of individuals who became divorced from their hospitals, or made a change, again for some reason or other, and noted how their patients followed them and stayed with them?

The general practitioner will not like this suggestion that the specialist should develop this type of practice. There is no answer other than to encourage the general practitioner to give better service and better medical care than anyone else, and to be more generous in his consultation demands so as to encourage a greater friendly relationship with the specialists.

What about the Boards? Certainly they demand that the gynecologist not take care of infants or men. They demand that he not perform general surgical procedures, orthopedics, urology, or the like. But they do expect him to use common sense. The gynecologist must be able to

give advice for the treatment of a back strain (pelvic organs normal), to treat an acute cystitis, advise as to the care of minor rectal problems, or treat his patient's cold or sudden gastrointestinal indiscretion. In other words, our young specialist must remember that he is a doctor first, and then a specialist.

The results of developing a large group of people who come to you for medical advice, regardless of your specialty, is a true form of economic security. These patients are concerned only with your service and your ability to get them well, and keep them well, be it in your hands or those of a referred physician. The majority tend to stay with you. You are their doctor. As this number grows and comes from many segments of society, the many social groups and the many unrelated friendly groups, your security is assured. Unless you become woefully inept, ill, or mentally unsound, your reputation among the public will grow and thrive, as will your practice. Such a practice shows a slow growth pattern, then a mushrooming effect, and finally a plateau of economic stability.

There are two more important, yea extremely important, points in the maintenance of your established practice: 1. Your health! A healthy attitude toward life, a respect for the worship of God, and proper moments of relaxation and planned vacations. 2. Your medical education! As you know, this is a never ending process. A study of the latest advances and the pooling of your knowledge with others as demonstrated at medical, scientific, and organizational meetings are a must.

Finally, the satisfaction that comes with a large practice is not just that of economic security, but the joy of having a patient say "Thanks, Doc.!" With this comes the realization blessed is mere man to be able to help in the work of God, be it ever so humble.

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## D.E.F.G.H.—

In the adult, environmental conflicts are potent sources of anxiety. Tredgold lists the stresses that produce anxiety in the mnemonic sequence of D, E, F, G, H, which represent domestic, employment, financial, group reactions, health, and housing factors. Regardless of the source of anxiety, the individual automatically seeks to escape the discomfort. If a serious conflict situation cannot be solved by constructive action, one of the so-called mental mechanisms may be employed. The more common ones include compensation, denial, displacement, fantasy, identification, projection, reaction formation, and substitution. The use of such mechanisms represents compromise and a certain amount of compromise is normal and universal. Abnormal dependence upon these defenses, however, not only alters the behavior patterns but produces dysfunctions which eventuate in disease. Although the process is not fully understood, some individuals can convert anxiety into a somatic symptom and, eventually, into functional disease. In contrast, a more serious defensive reaction is withdrawal into a fantasy life which, although it relieves anxiety, may cause the person to become schizophrenic. All of these methods of solving conflicts are negative and result in failure and abnormal or neurotic anxiety. *Anxiety. Psychiat. Bull. Summer,* 1956.

# THE P. R. PAGE

**Edward A. Uzemack, Director of Public Relations**

*Many favorable reports have been received on the first Legislative and Public Relations meeting held by the Committee on Medical Service and Public Relations, August 29 at the Hotel Sherman in Chicago.*

*Fifty chairmen of county society legislative and public relations committees attended the afternoon and evening sessions. A report of the meeting is published elsewhere in this issue of the Journal.*

*Among the comments on the meeting were expressions of hope that a similar program will be arranged for 1957, but at a different time of the year. An indication also was received that the American Medical Association's Law Department may cooperate with other state societies in arranging similar programs in lieu of the regional legislative meetings held in the past. If this is done it will mark another memorable "first" for the Illinois State Medical Society.*

*Probably the most flattering comment received on the Legislative-PR meeting was that the subject matter was "down to earth and very useful" to those who attended. This compliment was supported during the question and answer period which followed the afternoon talks. Scheduled for one hour, the period extended well beyond that time limit and had to be cut off because it threatened to run over into the dinner meeting. The sesion was jampacked with provocative questions and the panel of speakers seemed to have most of the answers.*

*Dr. Harlan English, 8th District Councilor and member of the A. M. A.'s Committee on Legislation, and Dr. Percy E. Hopkins, chairman of the Illinois State Medical Society's Committee on Medical Service and Public Relations, deserve much credit for the interesting pace they set for the meeting. Dr. English was program chairman and Dr. Hopkins served as toastmaster at the dinner session.*

*A transcript of the proceedings will be made available to the membership in the near future.*

*One of the most interesting phases of the program was an after-dinner address by Mr. John L. Bach, press relations director of the A. M. A. His subject was, "Who Is Going to Bell The Cat?" The following is a condensed version of his talk:*

BACK in our school days we were all acquainted with the ancient writings of a Greek named Aesop. He had a shrewd, analytical wit that was deceived neither by cant nor pious poses of righteousness.

The moral to one of his fables applies, in my opinion, to one of the key problems that exist in the relationship between physicians and medical science writers.

The Aesop fable concerns the Mice who were desperate because the Cat caught one or two of them every night. So they called a Council to decide how best to put an end to their troubles. Many plans were suggested and discarded; but

at last a smart young Mouse spoke up and said: Why not put a bell on the Cat, so that we can hear her coming? Everyone thought that this was really a fine idea, and a vote was about to be taken, when a shrewd old Mouse, who had kept quiet up till then, remarked: This is a perfect solution, but I have one little question I should like to ask: Who is going to bell the Cat?

And the moral is: It is one thing to make great plans; and another to carry them out.

I am referring to the countless letters which we receive from physicians who stress the evils of premature medical publicity and strongly urge that something be done to prevent science reporters from writing about medical remedies and discoveries before they have withstood the long, grueling tests of clinical research. Physicians would like to see some sound method for evaluating drugs before they are announced to the public. While there are many complaints on this score, no one to my knowledge has yet come up with a practical way for solving this problem.

How is any such plan going to be policed? How can you devise a plan that does not smack of censorship? How can you control in any way the day-to-day working assignments of at least 200 medical science writers throughout the country, not counting those who devote only part of their writing time to science? Who is going to take the initiative in instituting such a so-called governing agency—the medical profession, the medical school, the pharmaceutical industry, the research laboratory, or God forbid, the government? All of these groups, and many more, are involved directly, but who, I ask, is going to bell the Cat?

It is naive to believe that all of the firms manufacturing drugs can guard the secrets of their unproved theories. It is naive, too, to believe that they can do away completely with enthusiasm and optimism for any piece of particular research. It is naive to believe that all professional men—physicians, physicists, chemists, pathologists and other laboratory specialists—can keep their "miracles" under wraps for the long period of time which is usually required in any kind of drug research.

So again, I ask: Who is going to bell the Cat?

Confidence is often built up in ridiculous assertions through the power of the printed word. People generally believe that if they see something in print about a new drug or a new cure, it must be true. But that feeling is changing. There have been many false alarms, and the public is beginning to tire of reading about unfounded and unproved scientific claims.

The full-time medical science writer is gradually becoming aware of this. As proof, let me cite this example:

A few weeks ago we analyzed five newspaper stories reporting a new anti-diabetic drug. In the eyes of most physicians, all of these stories would fall into the classification of "premature publicity." Yet, all five pointed strongly to the fact that the drug is still in the experimental stage, and every one warned against "undue optimism."

As Steven M. Spencer of the Post once said: "No informed person expects science to move forward at a steady, unchanging pace. It is inevitable that medicine may occasionally take three steps upward and then find it must back down one step to secure a firmer foothold—but it has made a net gain of two steps. Surely the public is entitled to witness this progress, no matter how irregular and interrupted it may be."

I would like to switch now to the biggest single gripe which medical science writers hold against the medical profession. It concerns the use of physicians' names in medical articles appearing in newspapers and magazines.

We must be guided on this point by the Principles of Medical Ethics of the American Medical Association, which has been revised, or you might say liberalized, twice in the last six years.

Section five of the Principles does not touch specifically on the use of doctors' names in any media of public information. The Principles as applied on this score urges the physician to "seek the guidance of appropriate officials and designated spokesmen of component or constituent medical societies."

What, then, is the crux of this problem—with the writers pulling one way and the medical profession the other?

The answer is simple—there is no unanimity of opinion within the medical profession itself on the use of doctors' names in non-professional publications. Lake County, Indiana, may permit use of doctors' names, while Lake County, Illinois, does not. That situation exists all over the country, and it is difficult for the medical science writer to understand why one county

medical society permits use of names and another medical society does not; it is difficult for him to understand that, from an ethical standpoint, the matter rests entirely at the local level. The writers feel that ethical rules or opinions should be universal, not local.

Let me cite one example of why medical science writers are confused on this issue:

Several weeks ago, the Saturday Evening Post purchased a story from a free-lance writer, who told a dramatic story of how a team of 52 people at a hospital in an eastern state saved the life of a truck driver, virtually given up for dead after a highway accident. When the writer did his research on the story, it was agreed by all parties concerned that the real names of the six physicians involved would NOT be used. Fictitious names were substituted. However, the Post editors liked the story so well, they dispatched a photographer to the hospital and, luckily, he obtained all 52 people of the team in one picture. The 52 were assembled on the hospital steps and lawn. When the picture was to be tied up with the story, just before the magazine's deadline, the editors decided that the story itself had to carry the true names of the physicians involved. They reasoned that if they published a blowup of the picture and then carried fictitious names of the physicians in the text of the story, their readers, especially in the wide area where the hospital was located, would be confused. They felt, too, that if they carried out such a plan, the magazine actually would be performing a disservice and betrayal to its readers.

The Post editors contacted the county medical society officers. There was a long and serious wrangle about the use of the doctors' names in the story. The editors appealed to the A. M. A. for help, but there was nothing the A. M. A. could do since the decision itself had to be made at the local level; not the national level.

The end result was that the local medical society refused to approve the use of the doctors' names even though many of the officers freely admitted that the story was good for medicine and for the profession and that the story would do a good public relations job for both since the Post has a readership estimated at 16 million people.

The local medical society, even though it held a special meeting on the matter, based its action on the fact that the society's by-laws did NOT permit use of doctors' names. To change the by-laws would have required 90 days—much too long for the magazine to wait or hold its story.

The strained relationship between the medical society and the magazine was not good for medicine, of course. The result: the magazine paid off the writer for the work he had done, and junked the story . . . . a story which everyone admitted would have been GOOD for medicine.

My advice to you as chairmen of public relations committees of county medical societies is: check your by-laws on the use of doctors' names in newspaper and magazine articles. Ask yourselves: Are any of the by-law provisions on this point antiquated? Is my county medical society prepared to tackle such a problem, logically and fairly, if it ever comes up? Does my county medical society have a committee that is empowered to take appropriate and official action?

We must remember that all newspaper and magazine writers and editors believe that they can report newsworthy achievements of scientists with extreme care. A recent A. M. A. study shows some strong evidence to support this feeling. During 1955, magazines with a circulation in excess of one million published 320 articles dealing with medicine or the medical profession. A checkup shows that only 10 of these could be classified as bad or harmful. This means that 97 magazines last year were good for medicine and the profession.

The National Association of Science Writers, representing the "cream of the crop" in the medical science writing field today, has more than 200 members. Most of them are full-time science writers and many specialize in writing medical science exclusively.

These writers and their type of stories are here to stay—you can bet on that. More can be gained by working with them than against them. All of them carry a heavily-loaded gun, and they can fire it to mold public opinion for good OR bad.

It may be wiser and more fruitful to forget about ways to bell the Cat, and work more closely with the men and women who write about us. Learn to know them better. Let men of good will and good reasoning within the profession help to clear the obstacles from the path of medical communication. It will help medicine, and it will help the profession. That is our goal!

# CORRESPONDENCE



## Clinics for crippled children listed for November

Twenty six clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois Division of Services for Crippled Children. The Division will count 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing service. There will be three special clinics for children with cardiac conditions, one for children with rheumatic fever and one for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The November clinics are:

November 6 - Alton, Alton Memorial Hospital

November 6 - Casey, Casey High School

November 6 - Macomb, Marietta Phelps Hospital

November 7 - Hinsdale, Hinsdale Sanitarium

November 8 - Elmhurst Cardiac, Memorial Hospital of DuPage County

November 8 - Springfield, St. John's Hospital

November 8 - Sterling, Field House

November 8 - Watseka, American Legion Hall

November 9 - Chicago Heights Cardiac, St. James Hospital

November 13 - E. St. Louis, St. Mary's Hospital

November 13 - Peoria, Children's Hospital

November 13 - Shelbyville, Methodist Church

November 14 - Joliet, Will County T. B. Sanitarium

November 14 - Pittsfield, Illini Hospital

November 15 - DuQuoin, Marshall-Browning Hospital

November 15 - Litchfield, Madison Park School

November 15 - Rockford, St. Anthony's Hospital

November 16 - Evanston, St. Francis Hospital

November 20 - Fairfield, Fairfield Memorial

November 21 - Evergreen Park Little Company of Mary Hospital

November 27 - Effingham (Rheumatic Fever), St. Anthony's Hospital

November 27 - Peoria, Children's Hospital

November 28 - Aurora, Copley Memorial Hospital

November 28 - Springfield (Cerebral Palsy), Memorial Hospital

November 29 - Decatur, Decatur Macon Hospital

November 30 - Chicago Heights Cardiac, St. James Hospital

## A memo for you, doctor

If you're a typical doctor—you don't take advice from a woman. Nevertheless, a woman given the chance to speak, never refuses!

In Illinois 8,500 women care more for their husbands and their husbands' profession than do any other persons. Can 8,500 women do something for medicine in Illinois? Can we vote in November and see that our friends do, also? Can each reflect in her personal life, in everything she does—a trip to the grocer's, participation in the P. T. A., in the social atmosphere of the bridge club, through conversation with a neighbor—the devotion and care you exemplify in the practice of medicine? I think we can—if you want us to.

Not all of these 8,500 women are members of the Auxiliary, and membership in the Auxiliary isn't a necessary prerequisite. But in this day, when the impact of group activity is clearly demonstrated, shouldn't we use the strength of organized numbers, small indeed considering the job to be done?

May we help you by absorbing some of the responsibilities in community life which you are too busy to assume?

Only you can give us the facts and point the way. We want everyone to know the truth about you, your goodness, your sacrificies, your integrity; and finally, to realize the advantages that can be achieved only through "free medicine."

Doctor, the Auxiliary offers its service.

Mrs. Robert E. Dunlevy, President
Woman's Auxiliary to the I.S.M.S.

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## The American fracture association annual meeting

The annual meeting and postgraduate course conducted by the American Fracture Association will be held at the Drake Hotel, Chicago, November 28—December 1, 1956. On the first day, Wednesday, there will be a postgraduate fracture course at Cook County Hospital and the Drake Hotel. Details will be worked out and scheduled in the official program to be released soon.

For the next three days, the programs will be presented at the Drake Hotel and will cover the field of fractures, with the several types of treatment. An interesting program is being arranged which will be of interest to members of the American Fracture Association as well as others who treat fractures.

Complete information and the official program may be procured by writing to Dr. H. W. Wellmerling, Secretary, American Fracture Association, Bloomington, Illinois.

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## Have you asked your wife?

SOCIALIZATION OR ORGANIZATION
Which will it be?

Lethargy, long the arch enemy of organized medicine, has struck effectively once more. Cradled in the arms of Morpheus we enjoy a false security. What will it be, Doctors, a sound *organization,* or eventual *socialization?*

Have *you* asked your wife to join in the activities of the Medical Auxiliary? More than two thirds of the medical society must answer *NO!* On the surface it appears to be innocuous. On the contrary, could your Society exist with less than one-third of its potential strength realized? The obvious answer, of course, is that only in numbers is there strength. And the answer to the crucial problem of membership in the medical auxiliary lies with you.

Before taking up the accomplishments of the auxiliary, a few facts should be bared. The Illinois State Medical Society is at the highest level, (second only to New York) for membership in the compilation of statistics by the A.M.A. Yet, the Woman's Auxiliary to the Illinois State Medical Society ranks fiftieth on the national level. WHY? If each doctor in Illinois took his responsibility as a member of organized medicine seriously, he would realize the importance of his wife's membership in the auxiliary, and in so doing, our potential would be realized. You, Doctor, are the reason Illinois is not able to proudly demonstrate the excellence of her auxiliary, and utilize all her talents, which are so sorely needed in legislation, public relations, nurse recruitment, to mention only a few.

There exists a number of hypothetical questions. For instance, if my wife is unable to be active, i.e., incapacitated, small children, etc., what worth has her membership to the auxiliary? Answer: Your wife's dues are divided in such a manner that a portion is contributed to our State Benevolence Fund, and the remaining amount will help to support her county, state,

and national auxiliary. It is interesting to note that in some areas, the auxiliary dues represent one twentieth of the amount paid by a member of the Society per se.

The second part of the above question is more revealing. As a member, even though non-functioning, information is sent to her, and if digested, she will become a far more informed doctor's wife than from other attempts to impart medical information.

### WHAT A GOOD MEMBER CONSISTS OF

First let us presume that having resolved to marry a humanitarian, every doctor's wife in this state would understand that her obligation is to uphold, in every manner of speaking, the dignity and magnanimousness of her husband's chosen profession. Just as it remains the sacred calling for the physician, so should it remain for the woman chosen to go along this sacrificial path of life. And just as it is the doctor's moral obligation to join the society designed specifically for him, so is it, that the membership has been exclusively originated for his wife.

Further presuming that the doctor's wife is fully aware of the honor that is hers, as a member of the medical auxiliary, she will give of herself in any way that it is feasible. She will consider the auxiliary before any other form of organization within her community, and not place it in competition with others. She will realize that the hours spent in hospital service are but a part of her membership in the medical auxiliary. She will cherish her role of keeping medicine free from the ties that will ultimately inhibit and restrict it as a whole.

### HOW?

The very fact that you are a doctor's wife makes you different. Your role as a public relation's expert is far-reaching in every respect. And your contacts in organized medical auxiliary, schools you to that effect.

As a member of the auxiliary, your role will be to assist, wherever needed in important legislation. If you are a member of an organized county, your local legislative chairman will inform you of the work that is to be accomplished. Should you be a member at large, your chairman will keep you abreast of such pertinent information. You will be privileged to keep the eighty one medical schools in the United States free from government controls by aiding in the American Medical Education Fund, and its extensive campaign. Further, as a member, you can participate in the nurse recruitment programs, designed to further the education and welfare of our future nurses in America. And as a member of the Illinois medical auxiliary, you will be interested in being a contributor to benevolence. This fund artfully and anonymously assists physicians and their families who are no longer in a position to help themselves.

### DO IT NOW

If your wife *is* a member of the auxiliary, encourage her, and be proud that you are a team. If your wife is not an Auxiliary member, ask her to join you in membership today.

It is up to the doctors in Illinois to change the picture of organization in the woman's auxiliary. With just one word of encouragement, your wife will become a member. With just one word of encouragement, another county medical auxiliary can be formed. And with a few words of praise, we as an auxiliary, will rise to new heights and accomplishments that will reflect on the profession of which we are so proud. Shall we then resolve the problem of lethargy. *Which Will It Be: Socialization or Organization?*

For further information—Contact Organization Chairman/or your local Medical Society.

Mrs. Nicholas G. Chester
Organization Chairman
910 Park Avenue, River Forest, Illinois.

# AT THE EDITOR'S DESK



Dr. Alan E. Fisher, of the University of Wisconsin, was experimenting with animals to determine what type of brain stimulation causes certain behavior patterns. By injecting a male hormone into one part of the brain, male rats were driven to compulsive maternal behavior; when the same hormone was introduced into another area the sexual drive was altered. Then he stimulated both the maternal and sexual drives simultaneously in one animal. What happened? A crazy, mixed-up rat. It attempted to mate with a female not in heat, while carrying a newborn rat pup in its mouth. The rodent could not resist the temptation to mate even though its newly acquired maternal instinct had forced it to retrieve the wandering pup.

Your editors are looking forward to a new book on a low fat diet by Dr. and Mrs. Eugene A. Stead, of Duke University School of Medicine. The average American diet obtains 45 per cent of its total calories from fat. The Stead diet contains two-thirds less fat and reduces the caloric intake while preserving the fun of eating. The book outlines foods of low fat content and suggests ways of preparing them. For example, stew may be cooked partially, then refrigerated; before the final cooking the congealed fat on the surface is removed. There are white sauces without butter, French dressing and mayonnaise without oil, and whipped cream from skim milk.

"Step Lively . . . and Lose Weight" is a new leaflet on low calorie meal patterns that may be obtained from the American Dietetic Association. It is priced at 3c per copy or $2.00 per 100 lot orders.

Meat from stilbestrol-treated cattle is safe for human consumption, according to the U. S. Department of Agriculture. The hormone increases the rate and economy of gain in beef cattle without destroying the meat taste. Samples of meat from treated cattle showed no detectable amount of hormone, even though the cattle had been given larger doses of stilbestrol than permitted in commercial feeding.

One of the latest types of "falsies" is filled with birdseed; it was designed as a prosthesis to be used after mastectomy. A testimonial in its favor appeared in the June 9 issue of the British Medical Journal: "At long last we have found a substitute for the original which has adequate weight, natural shape, and authentic consistency. Furthermore, it neither rattles, leaks, nor sprouts . . . . My children no longer say, 'Mummy, your chesty has slipped.'"

News releases. Bonadoxin prevented morning sickness in 61 out of 65 pregnant women and one husband. Metamine Sustained provides oversimplified, enduring protection from angina pectoris. Radioactive gold is reported to be of value in cancer of the prostate. Cycloserine is available for the tubercular patient who fails to respond to all other therapeutic agents. The antibiotic is made by Lilly and by Pfizer and has helped some severe, resistant cases. It is not the agent of choice, however, because reactions such as convulsive seizures and mental disturbances occur in 8 per cent of the patients.

# NEWS of the STATE



## COOK

**Personal.**—Dr. Edward L. Compere, professor of bone and joint surgery, Northwestern University Medical School, was named president-elect of the American Section of the International College of Surgeons, September 9.

**Award Goes to J. Garrott Allen.**—The John Elliott Award of the American Association of Blood Banks has been presented to Dr. J. Garrott Allen, professor of surgery at the University of Chicago School of Medicine, for his research demonstrating that infectious hepatitis cannot be transmitted by liquid blood plasma which is stored at warm room temperatures for six months or longer. Dr. Allen's studies, begun twelve years ago, have shown that the virus of infectious hepatitis is killed by plasma storage at temperatures in the range of about 90 degrees Farenheit. Until Dr. Allen's work, plasma was generally stored either dried or under refrigeration, in the belief that otherwise it would deteriorate. The hepatitis virus remained active under these conditions, with 10 to 25 per cent of patients transfused with the plasma developing hepatitis. The threat of hepatitis had caused the abandonment of plasma transfusion.

The citation of the award reads "For orginal observations and clinical investigation which have established the safety of plasma stored at room temperatures insofar as the virus of serum hepatitis is concerned, thereby stimulating a revival of interest in the use of plasma as the preferred blood substitute and returning plasma to its appropriate place in hemotherapy."

**Pusey Memorial Lecture.**—Frederic E. Mohs, associate professor of chemosurgery, University of Wisconsin Medical School and director of the Chemosurgery Clinic, University Hospitals, Madison gave the tenth William Allen Pusey Memorial Lecture of the Institute of Medicine of Chicago at a meeting with the Chicago Dermatologic Society, September 20. His subject was "The Chemosurgical Method for the Microscopically Controlled Excision of External Cancer."

**Lighthouse for the Blind Observes Fiftieth Anniversary.**—"Changing Concepts of Rehabilitation—1956" formed the theme of a symposium commemorating the Golden Anniversary of the Chicago Lighthouse for the Blind, September 19. Speakers were from the field of business and industry: Mr. W. W. Tudor, vice president, Personnel & Employee Relations, Sears, Roebuck and Company, Chicago; from the field of medicine, Dr. Henry H. Kessler, the Kessler Institute, West Orange, New Jersey; from the field of welfare agencies, Mr. Samuel A. Goldsmith, executive director, the Jewish Federation of Chicago.

**Assistant Health Commissioner Named.**—Dr. Samuel L. Andelman, since 1952 director of the southern region of the Illinois Department of Public Health with offices in Carbondale, has been named assistant health commissioner of the Chicago Department of Health, effective September 4.

**Appointments at Northwestern.**—New appointments as assistant professors at Northwestern University Medical School are Drs. Zachary Felsher in dermatology; Frank Fara, in obstetrics and gynecology, and Harold Koenig, in neurology and psychiatry. The appointments were effective September 1.

**The Hamburger Lecture.**—Lewis Dexter of the Peter Bent Brigham Hospital, Boston, will present the Sixth Walter Wile Hamburger Memorial Lecture of the Institute of Medicine of Chicago, October 22, before a joint meeting of the Institute, the Chicago Society of Internal Medicine and the Chicago Heart Association. His subject will be "Valvular Regurgitation."

**Specialty Society Election.**—Dr. Norman J. Ehrlich was recently chosen president-elect of the Chicago Society of Allergy, and Dr. Helen C. Hayden was inducted into the presidency. Dr. Harold

C. Wagner, 104 South Michigan Avenue, Chicago 3, was named secretary-treasurer.

**Columbus Hospital's New Unit Under Way.**—Ground breaking ceremonies were held, August 14, for the construction of a million dollar six story addition to Columbus Hospital. The new unit, to be known as the Mother Antonietta Della Casa Research Center, will contain facilities for tumor treatment using cobalt in addition to x-ray therapy, medical research laboratories, additional operating rooms, the pediatric department, and beds for eighty-one patients. Construction will take about eighteen months. Mother Della Casa, for whom the addition will be named, is a former mother general of the Order of Missionary Sisters of the Sacred Heart which operates the hospital.

**Society News.**—Dr. Edmund Jacobson, Director of the Laboratory for Clinical Physiology, Chicago, delivered a paper in Brussels, August 2, at the International Physiological Congress, outlining the Physiological Basis for Psychiatry, including an objective and scientific evaluation of the state of the patient before, during and after any form of therapy, and describing new instruments for the electrical measurement of neuropsychiatric states.

## LAKE

**Personal.**—The transfer of Franklyn Newmark from the Lake-Sanders Country Medical Society, Montana, to the Lake Country Medical Society has been approved.

## LOGAN

**Society News.**—F. Garm Norbury, Jacksonville, Past President of the Illinois State Medical Society, addressed the Logan Country Health Improvement Association, August 30, on "Mental Health."

## MADISON

**Society News.**—"The Medical Profession's Business Relations" was the title of a paper presented by Dr. Robert Anschuetz, President of the Madison County Medical Society, before the society's September 6 meeting at the Madison County Sanitarium, Edwardsville.

## WINNEBAGO

**Postgraduate Course.**—The Illinois Academy of General Practice opened a postgraduate course in Rockford, September 27, which will continue through November 8. Another course will be held April 1 through May 10, 1957. The courses, which consist of two-hour sessions at weekly intervals, will be held in the Headquarters of the Winnebago County Medical Society, 310 North Wyman Street, 7:30 p.m. to 9:30 p.m. The subjects covered will be The Millenium in Obstetrics; Modern Concepts of Infectious Disease in Infants and Children; Emergency Room, and Hematologic Problems in Everyday Practice.

Participants in the courses are Drs. A. F. Lash, professor of obstetrics and gynecology, University of Illinois College of Medicine; Joseph R. Christian, associate professor of pediatrics, Stritch School of Medicine of Loyola University; Aaron Grossman, associate professor of pediatrics, Chicago Medical School; Harry A. Oberhelman, professor of surgery and head of the department at Stritch, and Steven O. Schwartz, associate professor of medicine, Northwestern University Medical School.

## ST. CLAIR

**Society News.**—Dr. Charles Doyle addressed the St. Clair County Medical Society, September 6, at the K. of C. Club, East Louis, on "Post-Phlebitic Syndrome."

**New Rehabilitation Center.**—St. Elizabeth's Hospital, Belleville, has opened a newly organized Rehabilitation Center for the treatment of the ill and disabled. It is to serve hospital patients, residents of the Home for the Aged and outpatients, according to the Bulletin of the St. Clair County Medical Society. The department is equipped to treat patients with heat in various forms, ultra sound, electrical stimulation, whirlpool, neck traction and exercises of various types including progessive resistance, parallel bars, shoulder wheel, mat work, and activities of daily living. A registered and licensed therapist is in charge. Method of referral is by written prescription. Hours in the department are from 8 a.m. to 4:30 p.m. Monday through Friday. Patients should ask for appointments.

## SANGAMON

**Fifty Year Club Members.**—Drs. Robert Flentje and C. R. Driskell were inducted into the Fifty Year Club of the Illinois State Medical Society at a meeting of the Sangamon County Medical Society, September 6. Presentation of the certificate and gold pin, emblematic of the club membership, was made by Dr. Jacob E. Reisch, Councilor of the Fifth District. Dr. Ralph E. Dolkart, assistant professor of medicine, Northwestern University Medical School, spoke at the meeting on "Principles of Use of Adrenal Hormones."

**New Officers.**—Dr. Jacob E. Reisch was named president of the Sangamon County Medical Society, June 3; Dr. W. P. Armstrong, vice president, and Dr. William DeHollander, secretary-treasurer. Drs. Frank M. Davis and Kenneth Schnepp were named to the board of directors for a three year term. Drs. Darrell Trumpe and Schnepp are delegates to the Illinois State Medical Society, and Drs. Thomas F. Harmon and J. Marvin Salzman, alternate delegates. All are to assume office, Jan. 3, 1957.

**Hospital Staff Election.**—At the staff meeting of St. John's Hospital, June 26, Drs. Frank M. Davis was elected president; William Bernard, vice president, and A. E. Steer, secretary. The various sections elected the following chairmen: Drs. H. B. Henkel Sr., surgery; Emmet F. Pearson, medicine; E. Harold Ennis, obstetrics, J. Keller Mack, pediatrics; John L. Schilsky, general practice; William DeHollander, X-ray, and David O. Holman, pathology.

## VERMILION

**Society News.**—Dr. Edward L. Quinn, physician in charge, division of infectious diseases, Henry Ford Hospital, Detroit, addressed the Vermilion County Medical Society at the Hotel Wolford, Danville, September 4, on "Advances in Virus Diseases."

**Personal.**—Dr. Vern Alder, Danville, has been accepted as a member of the Vermilion County Medical Society.

## GENERAL

**Fifty Years of Service.**—The Tuberculosis Institute of Chicago and Cook County has incorporated its 1955-1956 report in an attractive booklet titled "Fifty Years of Service." The brochure develops with text and illustration the history of the institute.

**Sorry, Dr. O'Neil.**—In the caption identifying the physicians in the Fifty Year Club luncheon photograph, August Illinois Medical Journal, the name Frank O'Neill should have read John P. O'Neil, a former Vice President of the Illinois State Medical Society.

**New Administrative Head for Hospital Group.**—Dr. Madison B. Brown, executive vice president and medical director of Hahnemann Medical College and Hospital, Philadelphia, has been appointed director of administrative services for the American Hospital Association, Chicago, according to the Chicago Tribune.

**Lectures Arranged Through the Educational Committee** of the **Illinois State Medical Society:**

**Lawrence Breslow,** clincial assistant professor of pediatrics, University of Illinois College of Medicine, Nettelhorst School PTA in Chicago, September 17, on Psychosomatic Illness of Grade School Children.

**Joseph N. Rappaport,** member of the pediatric staff of Evanston Hospital, Section 21 of the Illinois Vocational Homemaking Teachers in Elgin, September 22, on Understanding the Adolescent.

**Walter Oblinger,** Springfield, Associate Counsel, Illinois State Medical Society, Annual Joint Meeting of Physicians, Dentists and Druggists of Will-Grundy County in Joliet, September 26, on The Doctor's Legislative Footsteps: Here and in Washington.

**Sol Altschul,** assistant professor of psychiatry, University of Illinois College of Medicine, Woman's Auxiliary to the South Chicago Branch of the Chicago Medical Society, October 1, on Mental Health.

**Harry E. Rice, Jr.,** Aurora, member of the staffs of St. Charles, Copley Memorial and St. Joseph Mercy Hospitals, Woman's Auxiliary to the Will-Grundy County Medical Society in Joliet, October 9, on Advances in Medicine.

**Robert E. Lee,** associate clinical professor of medicine, Stritch School of Medicine of Loyola University, John C. Burroughs PTA, October 9, on Our Children's Health.

**John B. Hall,** Director, Cook County Department of Public Health, Sixth District of the Illinois Federation of Women's Clubs, October 10, on Poliomyelitis Vaccine.

**Armin H. Wolff,** Superintendent of the East Moline State Hospital, Henry County Home Economics Association in Orion, October 24, on Mental Health.

**Irving H. Rosenthal,** member of the pediatric staff at Mount Sinai Hospital, Sisterhood of Congregation B'nai Sholom of Garfield Park, October 24, on Emotional Needs of the Child.

**Paul K. Anthony,** clinical associate in pediatrics, Stritch School of Medicine of Loyola University, Paul Revere PTA, November 14, on Social Sex Attitudes in Adolescence.

**H. Paul Carstens,** clinical associate attending physician at Cook County Hospital, Lombard Nurses Club, November 16, in Lombard, on Heart Disease.

**Lectures Arranged Through the Scientific Service Committee** of the **Illinois State Medical Society:**

**Karl D. Venters,** chief of medicine at St. Mary's Hospital in Centralia, Williamson County Medical Society in Herrin, September 4, on Diagnosis and Treatment of Acute Pancreatitis.

**Louise Tavs,** clinical assistant professor of dermatology, University of Illinois College of Medicine, La Salle County Medical Society in Ottawa, September 20, on Dermatologic Lesions of Interest to the General Practitioner.

**William H. Requarth,** Decatur, assistant professor in surgery, University of Illinois College of Medicine, Knox County Medical Society in Galesburg, September 20, on Hand Injuries.

**John A. Mart,** associate in medicine, Northwestern University Medical School, Lee and Whiteside County Medical Societies, in Dixon, September 20, on Practical Aspects of Coronary Disease.

**George L. Drennan,** member of the pediatric staffs of Passavant and Our Saviour's Hospital's Jacksonville, Macoupin and Montgomery County Medical Societies in Carlinville, September 25, on Office Pediatrics.

**Marvin A. Rosner,** assistant attending obstetrician, University of Illinois College of Medicine, Rock Island County Medical Society in Moline, October 9, on Obstetrical Problems of Interest to the General Practitioner.

**John R. Wolff,** clincial assistant professor of obstetrics and gynecology, University of Illinois College of Medicine, Stock Yards Branch to the Chicago Medical Society, October 19, on Anorectal Complications in Pregnancy.

**William L. Riker,** pediatric surgeon, Children's Memorial Hospital, Chicago, Champaign County Medical Society in Champaign, November 8, on Cardiac Surgery, and DeKalb County Medical Society, in DeKalb, October 23, on Common Surgical Pediatric Procedures.

**John M. Coleman,** clinical assistant in medicine at Stritch School of Medicine of Loyola University, Effingham County Medical Society in Effingham, November 12, on Kidney Disease.

**Harry H. Garner,** professor of neuropsychiatry,

Chicago Medical School, Rock Island County Medical Society in Moline, November 13, on Psychiatric Problems in Medicine.

**Herman Chor**, attending neuropsychiatrist, Wesley Memorial Hospital, Chicago, Henry County Medical Society in Kewanee, November 14, on Psychiatric Correlation of Medical and Religious Approach to the Patient.

**James E. Segraves**, clinical assistant in bone and joint surgery, Stritch School of Medicine of Loyola University, Lee-Whiteside County Medical Societies in Dixon, November 15, on Treatment of Fractures of the Tibia with Special Reference to Intermedullary Rod Fixation.

**Casper M. Epsteen**, chairman, department of maxillo-facial and plastic surgery, Michael Reese Hospital, Kankakee County Medical Society in Kankakee, November 20, on Plastic Surgery: Facts and Fancy.

**Postgraduate Conference.**—On September 20, a Postgraduate Conference was held at the Elks Club, Harrisburg, under the auspices of the **Postgraduate Education Committee** of the **Illinois State Medical Society** in cooperation with the faculty of **Stritch School of Medicine of Loyola University**, and with the **Saline County Medical Society** acting as host. At the afternoon session, Dr. N. A. Thompson, Eldorado, a member of the Postgraduate Education Committee, presided, and Dr. George F. O'Brien professor and chairman of the department of medicine at Stritch, served as moderator.

The afternoon program consisted of three panel presentations on "Evaluation of Treatment of Arthritis"; "Differential Diagnosis of Abdominal Pain" and Peripheral Vascular Disease." Participants were Drs. Peter J. Talso, associate professor and assistant chairman of the department of medicine; Joseph L. Koczur, assistant clinical professor, department of pharmacology and therapeutics; Anthony C. Guzauskas, clinical associate in surgery; John B. Hoesley, clinical associate in medicine; James A. Rooney, clinical associate in surgery, and John H. Isaacs, clinical assistant in obstetrics and gynecology.

At the evening dinner session, Dr. Frank P. Skaggs, Harrisburg, President of the Saline County Medical Society, presided. Speakers were Edward A. Uzemack, Chicago, Director of Public Relations and Assistant Secretary of the Illinois State Medical Society, on "Making P. R. Purr", and Dr. Burtis E. Montgomery, Harrisburg, Councilor of the Ninth District, on "Current Medical Problems."

Wives of the visiting physicians were entertained by the Woman's Auxiliary to the Saline County Medical Society.

## DEATHS

**Franklin J. Corper***, Glenview, who graduated at Northwestern University Medical School in 1917, died August 25, aged 64. He was a member of the pediatric staff at the Evanston Hospital and a specialist certified by the American Board of Pediatrics.

**Earl E. R. Downing***, Chicago, who graduated at Bennett Medical College in 1914, died August 16, aged 73. He was a member of the staff of the Walther Memorial Hospital.

**Harold Feldman***, Pekin, who graduated at the State University of Iowa College of Medicine in 1932, was drowned in Carmel, California, May 20, aged 50, while attempting to save a woman swimmer from drowning. He was associated with the Pekin Public Hospital, and the Methodist and St. Francis Hospitals in Peoria.

**Frank Carl Fink**, Pleasant Plains, who graduated at Washington University School of Medicine, St. Louis, in 1904, died May 29, aged 75, of heart disease.

**Saviour R. Foty**, Oak Park, who graduated at Jenner Medical College in 1917, died May 9, aged 77, of coronary thrombosis. He was a member of the staff of the West Suburban Hospital.

**Willard Judd Johnson**, Decatur, who graduated at St. Louis University School of Medicine in 1904, died April 18, aged 81, of duodenal and marginal ulcers with stenosis.

**Maurice I. Kaplan***, Chicago, who graduated at Washington University School of Medicine, St. Louis, in 1910, died September 6, aged 68. He was head of the X-Ray Department of Mount Sinai Hospital from 1918 to 1934.

**Edgar V. Perkins***, retired, Chicago, who graduated at the University of Illinois College of Medicine in 1913, died August 28, aged 69.

**Alfred John Charles Schwartz***. Chicago who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1907, died June 3, aged 76, of carcinoma of the stomach.

**William Arthur Steele***, Havana, who graduated at Barnes Medical College, St. Louis, in 1896, died April 13, aged 88, of bronchogenic carcinoma.

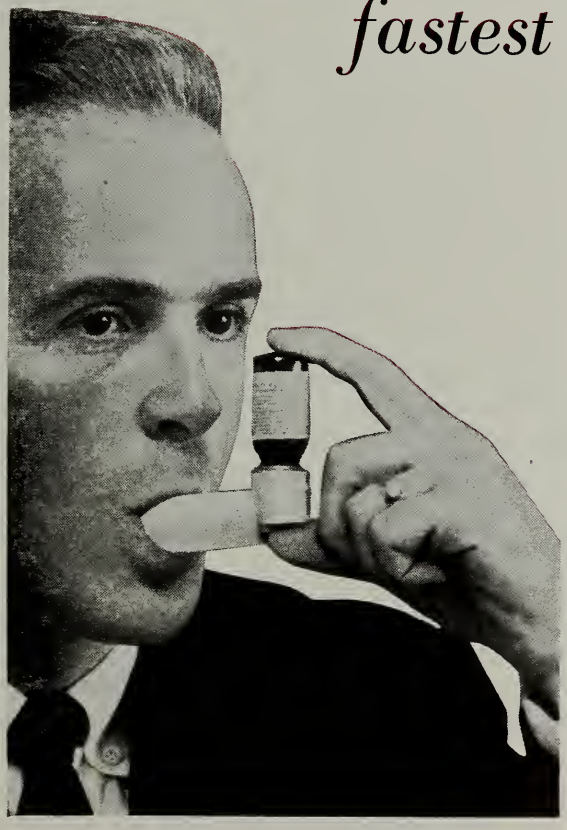
**William S. Timblin***, Rockford, who graduated at Rush Medical College in 1913, died August 8, aged 67.

**Howard Gunther Van Buren***, Hines, who graduated at the University of Illinois College of Medicine in 1950, died April 6, aged 37. He was associated with the Veterans Administration Hospital.

*Indicates member of the Illinois State Medical Society.

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## Russian medicine

Clearly, great improvements have now taken place in the state of Russian health, though they cannot be measured. It is not impossible that maternal and child mortality are now no greater than our own. Children are alert, vivid, and keen; they are blithe and gay. They crowd around the visitor in frank and disarming curiosity. But, as we have learned in Britain, it is easy to be misled in the absence of detailed records. The diet for both adults and children is almost certainly low in protein and there seem to be no measures of priority feeding. Nevertheless, improvements are likely to have been particularly marked in nutrition. Rickets, for example, which (together with osteomalacia) was very common before the revolution, is now rare in Uzbekistan, in contrast with its high prevalence in Turkey. We were told that rickety pelves have become rare (only 2-3 a year in 7,000 births in the Tashkent district maternity home), and this fitted in well for the low forceps and cesarean delivery rates (only 20 forceps and 11 cesarean sections). The main lethal pandemic and epidemic infections have probably been reduced to somewhere near the levels now seen in Western Europe. The position of typhoid seems to be not unlike our own and widespread inoculation, once practiced, has been abandoned as no longer necessary. The decline in tuberculosis also is likely to have been big despite the continuance of overcrowding; and since a quarter of 4,342 sanatorium beds of Uzbekistan were empty it is possible that the picture of tuberculosis in Russia now resembles that in Britain. *C. Fraser Brockington, M.D. Public Health in Russia. Lancet July* 21, 1956.

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A good college health program consists of far more than caring for the immediate needs of sick and injured students and teaching them good health habits. It has the responsibility of preventing illness or injury when possible, keeping aware of sanitary and environmental conditions that may be harmful and making appropriate recommendations, serving as an educational center for dissemination of information that may favorably affect the health of the community, and referring patients to specialized services when needed. *Dana L. Farnsworth, M.D., Bulletin NTA, May,* 1956.

## Self-centered

Often one of the most difficult diagnoses to make is that of childhood autism, or childhood schizophrenia, because the condition may be confused with any one of a number of other problems. The withdrawal of the morbidly autistic child may be so complete that he responds to few if any environmental stimuli; thus, when tested for hearing, he may fail to show any reaction and give the impression that he has a severe hearing loss. For the same reason or because his behavior may appear to be scattered and aimless and because he may be uneducable in the usual sense, the child may be classified as mentally retarded. In most instances, the latter diagnosis is erroneous, although occasionally childhood schizophrenia is found in conjunction with mental retardation. Language development may be confusing. Speech may never have developed or the child may have begun to talk and then stopped speaking or failed to progress in speech. If the child does not talk, his use of language—as his behavior in general—may be unusual, even bizarre. Perhaps the most significant indicator of schizophrenia, however, is the lack of any real interest in or response to others to the environment. While the child may cling to a parent or parent substitute, little or no affectation or outgoing interest characterizes the clinging. *Ruth M. Clark. Delayed Speech Development. Talk. June-July* 1956.

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Fifty malariologists, chiefly from Europe and the Eastern Mediterranean countries, met in Athens recently to discuss plans for the global eradication of malaria. A front line attack must be made in areas where there are still 250 million attacks each year and 2½ million deaths from the disease. The strategy of WHO is aimed at eliminating the disease throughout the world. The plan includes "spraying interior walls of houses with long-lasting residual insecticides should be carried out intensively and extensively until malaria no longer appears, and then the hidden pockets of infection must be sought out by means of fire-fighting techniques until all possibility of reinfecting the population is removed." Resistance to DDT has become a problem but they will continue using this insecticide until it becomes ineffective.


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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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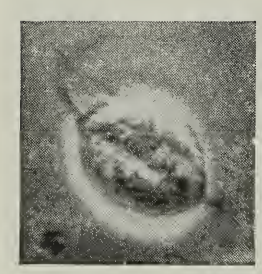
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*References:* 1. Davis, C. H., and Grand, C. G.: Am. J. Obst. & Gynec. *68*:559 (Aug.) 1954. 2. Davis, C. H.: West. J. Surg. *63*:53, (Feb.) 1955. 3. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955.

†Pat. App. for.

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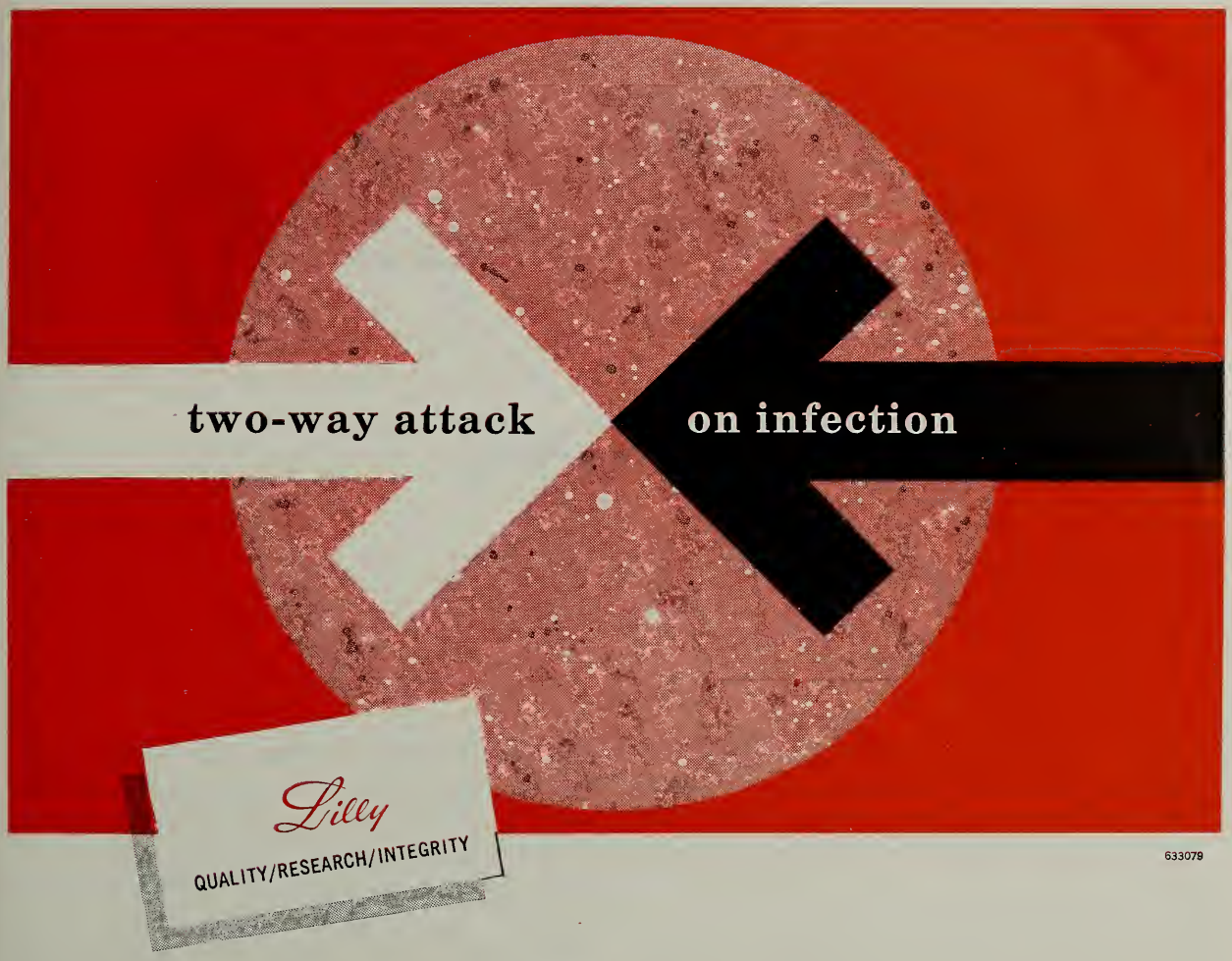
2 caps t.i.d.

1. Hardin, J. H.; Levy, J. S., and Seager, L.: South. M. J. 47:1190, 1954.

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# BOOK REVIEWS



A Course In Practical Therapeutics. Martin E. Rehfuss, M.D. and Alison H. Price, M.D. 972 p.p:-illustrated Third Edition-1956. The Williams & Wilkins Co. Baltimore. Price $15.00.

The previous editions of this book were very popular among physicians everywhere. It was written for both practicing physicians and students of medicine in the upper grades, and as would be expected, with the many new therapeutic agents added each year, many revisions and additions appear in this 1956 volume.

The list of collaborators has been increased and for the third edition, a total of 24 contributors have made this fine book available. More illustrations also appear in this edition which add considerably to its value to physicians and medical students. The modern treatment of disease is well described, and controversial problems are discussed.

The book is divided into four sections; the first, dealing with general therapeutic principles. Much basic information will be found in this section concerning the development of plans for treatment, considerations of prescription writing, the various types of therapeutic agents, and dietary principles. One of the highly interesting features in this section is the contents of the physician's bag. This has long been a confusing problem on the part of the practitioner, and the authors give their own ideas on that important problem.

The second section deals with symptomatic therapy, and applies in great measure to the treatment of emergencies. The third section is entitled "Treatment of Specific Disorders," which requires the major part of the space in the book.

The fourth section deals with special treatment and in this section appears many new items in addition to many revisions from the former edition. An excellent evaluation of the numerous antibiotics is made, along with the many new types of therapy including radioactive isotopes.

Again we predict that this will be a welcome addition to any physician's library and will be placed where it is constantly available for reference on the important subject of proper therapy for many types of ailments. The book has a well developed index which makes it easy to find any subject in a hurry. This is of course, not a pocket edition but one large enough that it will show up like a swollen thumb, and properly should be on the physician's desk or a nearby table for quick, ready reference.

‹ ›

SURGICAL DIAGNOSIS By Philip Thorek, M.D., F.A.C.S., F.I.C.S. Professor of Surgery Cook County Graduate School of Medicine: Clinical Associate Profesor of Surgery; University of Illinois College of Medicine; Diplomate of the American Board of Surgery; Co-

(*Continued on page* 66)

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## BOOK REVIEWS (Continued)

Surgeon in Chief of the American Hospital; Attending Surgeon of Cook County Hospital; Senior Attending Surgeon, Alexian Brothers Hospital; Member of American Association of Anatomists; Fellow of the American College of Chest Physicians. With drawings by Carl T. Linden, Assistant Professor of Medical Illustration, University of Illinois College of Medicine. J. P. Lippincott Company, Philadelphia—Montreal. 320 pages.—$12.00.

At the outset, in his preface, the author stresses the importance of a "simple, concise and workable plan" for investigation.

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The author's handling of each anatomical part is thorough, covers practically every diagnostic problem of the part. The text is succinct; there is not any unnecessary word in the whole volume. The text is replete and overlooks nothing of diagnostic value.

The illustrations in this volume are most in-

(*Continued on page* 68)




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## BOOK REVIEWS (Continued)

teresting, are very numerous and are quite applicable. These are done by Carl Linden.

Dr. Thorek does not minimize the "modern approach to diagnosis"—namely the tendency to make the "laboratory primary." It is his opinion that scrupulous attention to the four items permits diagnosis to be correctly made "long before" the laboratory information may be available.

The book is very nicely printed and all in all is much more valuable than indicated by its intrinsic value.

There is no bibliography and no list of references.

C. P. B.

### BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Sleep. By Marie Carmichael Stopes. Doctor of Science, London; Doctor of Philosophy, Munich, Fellow of the Royal Society of Literature, etc. Philosophical Library, New York. $3.00.

Observations on Krebiozen in the Management of Cancer. By A. C. Ivy, Ph. D., M. D., Distinguished Professor of Physiology and Head of the Department of Clinical Science, University of Illinois, John F. Pick, S. B., M. M., M. D., Head of Department of Plastic Surgery, Columbus Hospital, Chicago, and W. F. P. Phillips, M. D., Department of General Practice, St. Francis Hospital, Evanston, Illinois. Henry Regnery Company, Chicago. $2.50.

How to get Industrial and Business Publicity. By Charles E. St. Thomas. Publishers, Chilton Company, Philadelphia. $5.00.

Dermatology. By Donald M. Pillsbury, M.A., D. Sc. (Hon.), M. D., Walter B. Shelley, M. D., Ph. D., and Albert M. Kligman, M. D., Ph. D. 1331 pages, 564 figures. W. B. Saunders Company, Philadelphia and London. $20.00.

Roentgen Signs in Clinical Diagnosis. By Isadore Meschan, M. A., M. D., with the assistance of R. M. F. Farrer-Meschan, M. B., B. S., (Melbourne, Australia). 1058 pages. 2216 on 780 figures. W. B. Saunders Company, Philadelphia and London. $20.00.

An Atlas of Anatomy. By J. C. Boileau Grant, M. C., M. B., Ch. B., F. R. C. S. (Edin). Professor of Anatomy in the University of Toronto. By regions —upper limb, abdomen, perineum pelvis, lower limb, vertebrae, vertebral column, thorax, head and neck, cranial nerves and dermatomes. Fourth edition. The Williams and Wilkins Company, Baltimore. $15.00.




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2. We have an obligation to help those who wish to know the truth by participating in public service programs such as radio, television, newspaper, and community organizations when invited.

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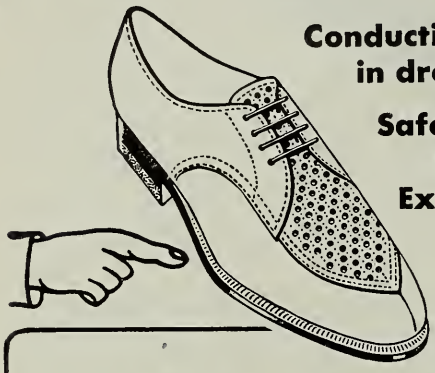
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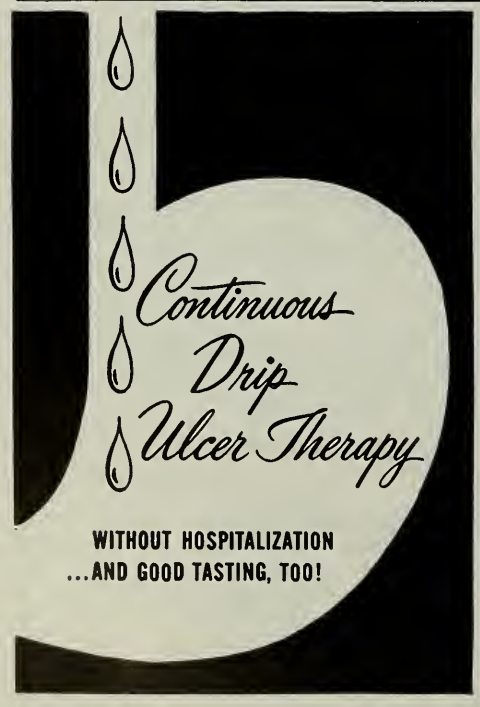
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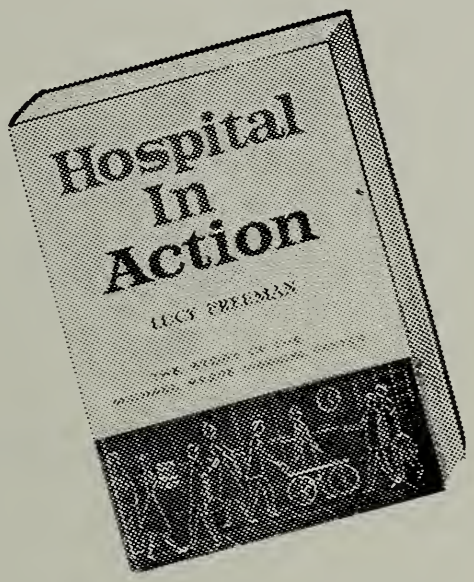
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*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

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Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

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Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Send change of address on form 3579 to 1501 W. Washington Road, Mendota, Illinois.

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[1]Posner, A. C., *et al.;* Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

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# The Month in Washington



In addition to helping states make monthly public assistance payments to certain indigent persons, the federal government for a number of years also has contributed to the cost of their medical care. Because the grants formula is somewhat complicated, and the amount of medical care varies with the states, this U. S. contribution cannot be fixed definitely. It is estimated at about 90 million dollars a year.

About a third of the states now deposit these federal grants—which must be matched 50-50—in a separate fund, from which the medical care costs are paid directly to the vendors, such as physicians, dentists, hospitals, nursing homes and druggists. The remaining two-thirds include medical care costs in monthly checks to the indigent, and expect these people to pay their own medical bills.

But beginning next July 1, this U. S. -state medical care arrangement is going to be drastically altered.

For one thing, the U. S. will increase its payments from the current $90 million a year to between $200 million and $300 million. For another, *all* medical care money under the new program will be put into a separate fund, from which the indigents' medical bills will be paid, in one way or another, by the state itself.

It is true that in some states the new program will not have much effect. This will be the case with those states that already have a substantial medical care program and see no reason for increasing it and with those unable to raise the matching money.

But the amount of money potentially available to each state is significant, and in most states the change-over from the old to the new systems will have an important effect on physicians and other vendors of medical care. For example, eight states will have "new" medical care funds in excess of 10 million dollars, if they put up half the money. California's potential fund is $27 million and New York's and Texas' more than $18 million each.

Before state welfare directors can start operating under the new program they will have to decide (a) whether they will require doctors to agree to a fee schedule, if one is not already in operation in their indigent care program, and (b) how the doctors will be reimbursed (whether through their societies or other mechanisms, or directly by the government). Some state welfare officials already have approached state medical societies to talk over the situation.

(U. S. contributes to indigents in only four categories—the aged, dependent children, the blind and the disabled. For their medical care, it will offer states $3 per month for each adult and $1.50 for each child, money which the state must match. It is out of these funds that payments will be made for medical care.).

**NOTES**

Because most applicants did not supply enough information, the council in charge of grants for medical research facilities approved only a handful of projects at its first meeting. Although $30 million was available, only $764,

(*Continued on page* 26)




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**WASHINGTON (Continued)**

159 was allocated. Money went to seven institutions. However, the expectation is that fund will be just about exhausted at the December meeting of the council, as more than 250 hospitals, schools and laboratories have asked for money.

First head of the new National Library of Medicine is the man who steered the Armed Forces Medical Library through the last seven troubled years—Col. Frank B. Rogers. He is on loan to PHS, which is in charge of the new institution to be built up around AFML.

Hearings will be held probably in December by the House Interstate and Foreign Commerce committee on federal aid to medical education. The expert panel system will be used, instead of lone witnesses. Currently the committee staff is analyzing information received in response to questionnaires sent out to about 60 organizations interested in medical education.

A six-man advisory committee, named by Secretary Folsom, is attempting to work up suggestions that will help hospitals improve care and reduce costs. Some possibilities: central cafeterias for ambulatory patients, light housekeeping work done by some patients themselves.

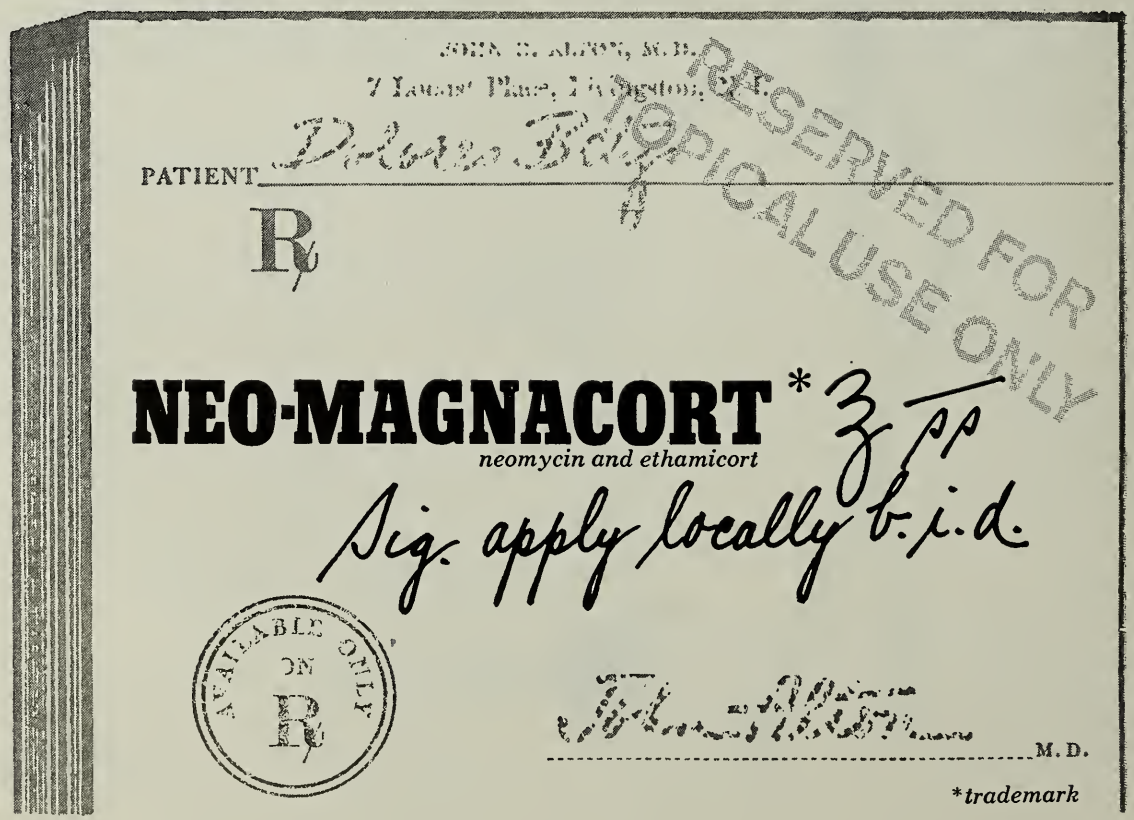
Regional Small Business Administration offices now are taking applications for loans to three types of health facilities—hospitals, nursing homes, and medical and dental laboratories. Institutions must be "small" and must be run for private profit.

‹ ›

## No dues

The great joy of not belonging to the Br*t*sh M*d*c*l *ss*c**t**n is that each year you receive a delightful letter from the secretary. It is quite the nicest letter of the year. He sets out in immaculate English, with wit, charm, and unerring logic, the advantages of joining. My first reaction always is: "What a fool I am not to have joined." Out comes my pen and I start to fill in the banker's order. But then I have second thoughts: "If I sign now, then there will be no letter next year. One of the minor pleasures of life will have been lost forever." Once again I have put my pen away and selfishly look forward to next year's letter. *In England Now. Lancet, July* 14, 1956.

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The
ILLINOIS
Medical Journal




**Official Journal of The Illinois State Medical Society**

NOVEMBER, 1956
VOL. 110. NO. 5

# Changing the Face of the World

**Paul R. Cannon, M.D., Chicago**

THE interesting events connected with the development of the poliomyelitis vaccine, and particularly the difficulties encountered in its manufacture and therapeutic assessment are mainly responsible for the preparation of this paper. The paper itself represents a sort of look-back to a series of dramatic happenings centering around and leading up to the development of the first vaccine against an infectious disease, namely, smallpox. In those days smallpox was a vastly more terrifying disease than is poliomyelitis today. If, tonight, we could mount a magic carpet and in imagination sail away to the London of two centuries ago, where, transformed in time and space, we could listen to the reading of this paper, many of us would have pock-marked faces and all of us would be fortunate to have faces at all. For in 1756 smallpox was probably the greatest single killer and disfigurer of mankind. Its conquest represents a supreme medical achievement, an achievement unfortunately often forgotten, mainly because of complacency, but usually at a heavy cost to the forgetter. For example, in the United States Army in World War II, 115 cases of smallpox were reported, with 24 deaths; and in 1945 and 1946, among the American troops in Korea and Japan, 126 cases were reported with 25 deaths. Even in England, and as late as 1953, an epidemic occurring in a manufacturing area caused five deaths and threw consternation into those who were preparing for the coronation ceremonies for Elizabeth II. These happenings represent mostly a carelessness in vaccination enforcements. However, they may also indicate a failure of some vaccine viruses to protect against virulent smallpox. In New York City in 1947 the appearance of 2 cases of smallpox, with one death, led to the immediate vaccination of some 5,000,000 persons. And yet, as a result of vaccination, there are many physicians throughout the world who have never seen a patient with smallpox, and today one can walk the city streets and scrutinize the countenances of scores of persons without seeing a single pock-marked face.

If one is inclined to believe that the Salk vaccine has encountered unusual difficulties, one should compare its vicissitudes with those of the Jenner vaccine. Although the events accompanying the field trials of the former were unfortunate and unanticipated, at least no anti-vaccination societies have as yet been organized to combat it, no one from the pulpit has been stigmatized as diabolical or anti-Christ, no mobs have formed to prevent its use, and Dr. Jonas Salk has not been accused of "monkeyizing" or

*Department of Pathology, The University of Chicago.*

*Presented before the Chicago Society of Medical History, April 11, 1956.*

bestializing the human species. In contrast, Edward Jenner's vaccine, so named from the word vacca, meaning cow, was alleged to promote the growth of cow's horns, faces and tails, to make people cough and bellow like bulls, and in other ways to bovinize countless beef-eating and milk-drinking Englishmen.

Several interesting comparisons may be made with reference to the development of the two vaccines. For example, the March of Dimes would not have gained its favorable momentum had it not been for the earnest support of President Roosevelt. Similarly, vaccination against smallpox in America would doubtless have been considerably delayed had it not been for the active interest of President Jefferson in the experiments of Dr. Benjamin Waterhouse. Success of the poliomyelitis vaccine was based on groundwork laid by many earlier investigators, work which eventuated in a method of tissue culture suitable for the growth of the virus in monkey kidneys. The development of the cowpox vaccine was also based on earlier evidence that inoculation with smallpox matter could prevent smallpox and from observations by milkmaids that, because they had had cowpox, they could not contract smallpox. Many years elapsed before vaccination of children with poliomyelitis virus, even though dead, became thinkable; and even now some experts believe that eventually we will have to use a living virus. In launching the polio vaccine program accelerated as it was by the desire of its promoters to save life and prevent deformity, haste made waste. This was not a complication with the cowpox vaccine. Almost 28 years passed from the time that Edward Jenner got the idea until he did anything in particular about it. In fact, he was only 19 years old when he was told by a patient she could not take smallpox because she had had cowpox. Jenner was 48 when he published his classic Inquiry.

For many years Jenner talked so much about the cowpox that he became a veritable nuisance to his medical friends; they thought he had a bee in his bonnet; and while he was talking millions continued to sicken and die, to become disfigured or blind, from the effects of smallpox. It would be interesting to know why he took so long to put his theory to the test, knowing as he did the horrors of the disease. But even after John Hunter had told him, "Dont think, try," the years rolled on. It may be that the attributes of indolence and procrastination which Jenner so freely attributed to himself may have been responsible; more probably the times were not conducive to experimentation as we practice it today. At any rate there is nothing new about time-lags in science. For example, Dr. C. P. Rhoades of New York City has recently commented upon the subject as follows: Although the relationship of the pancreas to diabetes was clearly shown in 1889, and even before World War I pancreatic extracts were known to lower blood sugar levels, insulin was not found until 1922. About 18 years elapsed between the discoveries of Pasteur and their application by Lister. Pasteur demonstrated the principle of antibiosis in 1877 but Fleming did not discover penicillin until 1929. The antibacterial action of sulfanilamide was demonstrated by two scientists in New York City in 1919, but the substance was put on the shelf and presumably not dusted off again until Domaghk received the Nobel prize for his work with it in 1935. The nature of scurvy was known almost a century before the British Navy did anything about it. In the meantime "the very existence of Great Britain was jeopardized during all of which time the Navy was making countless appeals for more men to man the fleets." "Only the ineptitude and corruption of the Napoleonic regime prevented it from breaking the seapower of England, with her sea-going manpower decimated by uncontrolled and wholly unnecessary deficiency disease."

Although the origin of smallpox, or variola, is obscure, it was presumably known in China at least a thousand years before the birth of Christ, and it is said that temples were erected in its honor in which the goddess of the disease was glorified. In those times, also, inoculation or "sowing the smallpox" was practiced. And even today in China, I am told, the red pockmarks representing recovery and immunity to the disease are referred to as "the flowers of heaven." It also seems to have existed in India long before the Christian era. There is doubt, however, that Greek physicians were familiar with it. It appeared in England some time between the sixth and tenth centuries and is thought to have been brought to America by Columbus where it quickly spread among the Indian tribes. It appeared among the New England colonists in about 1631 and from then on

epidemics recurred in the succeeding century with devastating effects. Thus in Boston, in 1752, an epidemic occurred in which, out of a population of over 15,000, only 174 people remained who had never had the disease. It apparently reached its zenith in Europe in the 18th century at which time every tenth death was attributed to it, and estimates indicate that during this century more than 60,000,000 persons perished from the disease. It spared neither king nor peasant; among its victims may be cited the following: William II of Orange, Emperor Joseph I of Germany, Louis XV of France, two children of Charles I of England, a son of James II, his daughter Queen Mary and his grandson, the Duke of Gloucester, two German Emperors and six Austrian archdukes and duchesses. Empress Maria Theresa of Austria nearly died from it in her later years. In general, however, its victims were mostly children.

No account of smallpox would be complete without citation of the well-known passage from Macauley relative to the death in 1694 of Queen Mary, wife of William III. "That disease, over which science has since achieved a succession of glorious and beneficent victories, was then the most terrible of all the ministers of death. The havoc of the plague had been far more rapid; but the plague had visited our shores only once or twice within living memory; and the smallpox was always present, filling the churchyards with corpses, tormenting with constant fears all whom it had not yet stricken, leaving on those whose lives it spared the hideous traces of its power, turning the babe into a changeling at which the mother shuddered, and making the eyes and cheeks of the betrothed maiden objects of horror to her lover."

In Henry Esmond, written by Thackeray about a century ago, is the following: "Since Lady Mary Wortley Montagu brought home the custom of inoculation from Turkey (a perilous practice many deem it, and only a useless rushing into the jaws of danger) I think the severity of smallpox, that dreadful scourge of the world, has somewhat been abated in our part of it; and remember in my time hundreds of the young and beautiful who have been carried to the grave, or have only risen from their pillows frightfully scarred and disfigured by this malady. Many a sweet face hath left its roses on the bed on which this dreadful and withering blight had laid them. In my early days, this pestilence would enter a village and destroy half its inhabitants; at its approach, it may well be imagined not only the beautiful but the strongest were alarmed, and those fled who could." In chapters VIII and IX Thackeray gives a detailed description of the terror connected with the appearance of smallpox near Castlewood House and its consequences in terms of death and demoralization.

Prior to the era of preventive medicine, treatment for the disease was largely unavailing. During the humoral period, that is, until almost 1850, the most important therapeutic problem, apparently, was to drive out the peccant humours. This was done mostly by sweatings and by applications of heat. Illustrative of this was the treatment by John of Gaddesden, physician to Edward II, at about 1320. His prescription was to wrap the patient in a red cloth and to enclose the bed entirely in hangings of a red color, presumably to bring the peccant humours to the surface. Improvement in therapy came when Sydenham, in about 1667, began his reform by demanding plenty of fresh air and cooling treatments for febrile patients. But smallpox, as we now know, was usually complicated by bacterial infection of the cutaneous lesions, and death was commonly a consequence of overpowering sepsis. It would, of course, be much less menacing today because of the availability of chemotherapeutic and antibiotic agents.

In Europe and America the first steps along the path leading up to vaccination came early in the 18th century. The procedure of variolation, namely, the introduction of smallpox matter into human subjects, came almost simultaneously in Europe and America, in England largely because of the efforts of Lady Mary Wortley Montagu, wife of the British Ambassador to Turkey. In her classic letter to a friend in London, written on April 1, 1717, we find the following: "apropos of distempers, I am going to tell you a thing that will make you wish yourself here. The smallpox so fatal, and so general amongst us, is here entirely harmless, by the invention of *ingrafting,* which is the term they give it. There is a set of old women, who make it their business to perform the operation, every autumn in the month of September, when the great heat is abated.

"People send to one another to know if any of their family has a mind to have the small-pox! They make parties for this purpose, and when they are met (commonly fifteen or sixteen together), the old woman comes with a nut-shell full of the matter of the best sort of small-pox, and asks you what vein you please to have opened.". . . . . "The children or young patients play together all the rest of the day, and are in perfect health to the eighth. Then the fever begins to seize them, and they keep their beds two days, very seldom three. They have very rarely above twenty or thirty in their faces, which never mark, and in eight days they are as well as before their illness. Where they are wounded, there remain running sores during the distemper, which I don't doubt is a great relief to it.

"Every year thousands undergo this operation; and the French Ambassador says pleasantly, that they take the small-pox here by the way of diversion, as they take the waters in other countries. There is no example of anyone that had died of it; and you may believe that I am well satisfied of the safety of this experiment since I intend to try it on my dear little son.

"I am patriot enough to take pains to bring this useful invention into fashion in England, and I should not fail to write to some of our doctors very particularly about it, if I knew any of them that had virtue enough to destroy such a considerable branch of their revenue, for the good of mankind. But that distemper is too beneficial to them, not to expose to all their resentment, the hardy wight that should undertake to put an end to it. Perhaps, if I live to return, I may, however, have courage to war with them. Upon this occasion admire the heroism of your friend."

Her son was inoculated that year and all went well. When Lady Montagu returned to London the following year she tried, but with not much success, to get the procedure accepted, particularly in Court circles. By 1721, however, smallpox was raging in England and at this time she had her four year old daughter inoculated. After much effort she finally persuaded King George I to allow the inoculation of his two granddaughters. Being a cautious king, he asked to have the procedure tried first on some inmates of Newgate prison. The prisoners were inoculated, all had takes, and one was sent to an epidemic area where he failed to contract the smallpox. Thus at long last, as a later king of England was to phrase it, the first George consented to have his granddaughters inoculated, and himself as well.

In the succeeding seven years, i.e., up to 1728, approximately 897 persons were inoculated, with a total mortality of 17.

The importance of variolation was recognized in America independently of the efforts of Lady Montagu, again largely because of the zeal of a layman, the Reverend Cotton Mather. There is reason to believe, moreover, that he was a reader of the Philosophical Transactions of the Royal Society and that he was for that reason familiar with the writings of two Greek physicians, Timoni and Pylarini, who had published in the Transactions their experiences with variolation in Constantinople. These papers were recorded in 1714 and 1716. Even earlier Mather had learned from a negro slave that it was a common practice in Africa to introduce smallpox matter into the skin and thus protect against the disease. Although Mather was ridiculed for believing such stories, he was probably the first to call the attention of Europeans to the practice of inoculation in Africa (Leikind).

When smallpox appeared in Boston in April of 1721, Mather, with his mind prepared for this contingency, took up the question of inoculation with the ten physicians in that city. None, however, seemed to be interested in his proposal, none, that is, except Dr. Zabdiel Boylston. Dr. Boylston, a respected physician, agreed to cooperate and he began by inoculating his six-year old son and two negro slaves. All went well so he proceeded to inoculate 35 persons, with no deaths. In the meantime, opposition began to grow and it mounted to the point where Dr. Boylston almost lost his life from the fury of a mob and his home from an attempt to set it on fire. A bomb was also thrown into the house of Cotton Mather while Mrs. Mather was at home, but the cap fell off and the bomb failed to explode. The press was also solidly against both Mather and Boylston and it is interesting that the sixteen-year old Benjamin Franklin and his brother made vicious attacks upon Dr. Boylston in their newspaper. The Massachusetts House of Representatives also passed a bill against inoculation; this, however, failed to become a law. It is of further interest that many years later, in

1736, Franklin bitterly regretted his earlier attitude, after his four-year old son had died from smallpox. Of this he said, "A fine boy of four years old, by the smallpox taken, in the common way. I long regretted bitterly and still regret I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they shall never forgive themselves, if a child died under it, my example showing that the regret may be the same either way, and therefore that the safer should be chosen." Despite all opposition, Boylston continued to inoculate during 1721 while the epidemic raged, but by 1722 the disease was on the wane and he discontinued inoculations. In a quotation from a History of the Province of Massachusetts Bay, it is said that in 1721 and 1722, some 286 persons were inoculated; of these only six died, and several of those inoculated were supposed to have been infected with smallpox at the time of the inoculation. In contrast, of some 5,889 persons who contracted smallpox, but without inoculation, 844 died; and many who recovered were, of course, severely pockmarked.

Years later, in 1759, Dr. Boylston was elected to the Royal Society, one of the first Americans so honored.

During these years inoculation was practiced both in America and in England, particularly among the upper classes. Smallpox parties were formed, and people went to the hospital to have the disease together. Although there can be no doubt but that inoculation greatly reduced the mortality from smallpox and that it protected against future attacks, the practice was not without risk, either of death or disfigurement; and because it was smallpox, it tended to maintain and even disseminate the infection. As late as 1776, however, the soldiers in the Revolutionary armies suffered so much from the disease that General Washington ordered the whole army to be inoculated. This was done, hospitals being set up in several cities. As Leikind has said, this was "probably the greatest mass experiment of its type ever attempted up to that time."

By the latter quarter of the 18th century, however, it had become apparent in England that the disease was gaining ground and that variolation was not the answer to the problem of control. The next chapter was that of vaccination; in this one name stands supreme, that of a gentle country doctor by the name of Edward Jenner.

What kind of a man was this who did so much to change the face of the world? On his monument are inscribed the following lines:

Within this tomb hath found a resting place
The great physician of the human race
Immortal Jenner, whose gigantic mind
Brought life and health to more than half mankind.
Let rescued infancy his worth proclaim
And lisp our blessings on his honored name,
And radiant beauty drop her saddest tear
For beauty's truest, trustiest friend lies here.

Allowing both for poetic license and presumably for bad poetry as well, why did this man among all others discover the clue to the conquest of this overwhelming pestilence? Evidently in many ways he was a very ordinary person, kindly and lovable, possessed of great loyalty to his brother and his friends, fond of good food and good wines, of music and poetry, of nature and of his fellowmen. He was apparently unsystematic, was not adept in the use of his hands and in fact was scolded by John Hunter for his clumsiness in breaking a thermometer while taking temperatures of hibernating hedgehogs. He was also inclined to indolence and procrastination and said, "of all the ill habits a man may fall into, the most difficult to get rid of" and "this very sin has got me into more scrapes than all the rest put together."

Despite these attributes he practiced medicine conscientiously, was at one time justice of the peace and also mayor of Berkeley. Above all, however, for years he had a fixed idea, and it was that which made him great.

During the many years in which Jenner thought about the relationship of cowpox to smallpox he apparently had only occasional opportunities to put his ideas to the test. But in 1796 an outbreak of cowpox occurred on a farm nearby. An infected milkmaid by the name of Sarah Nelmes had pustules on the hand. Jenner took matter from one of these and inoculated it into a boy by the name of James Phipps. This occurred on May 14th, 1796. After the boy had gone through the customary course of cowpox the crucial test was made. Six weeks later, on July 1, Jenner inoculated the boy, but this time

with smallpox matter. The inoculation failed to take; and as Leikind has said, "thus was vaccination born." This marked the "first step in the scientific prophylaxis of disease" (Castiglioni).

Because Jenner was a member of the Royal Society, for reasons to be mentioned shortly, he decided to communicate his findings to that body. His manuscript was summarily rejected with the remark that if he valued his reputation he should be more careful of it, or words to that effect. It might be added at this point that his membership in the Royal Society was based on his earlier observations on the habits of the cuckoo. But Jenner was not dismayed, and after two more years, he published his first report in the now classic monograph, "An Inquiry Into the Causes and Effects of the Variolae Vaccinae, A Disease Discovered in Some of the Western Countries of England, Particularly Gloucestershire, and Known by the Name of the Cow Pox." This was in 1798. In the words of Victor Robinson, "It is a small pamphlet, with three engravings of arms, and the picture of the hand of Sarah Nelmes, showing the position and development of the pustules. It is a rather delicate hand, with tapering feminine fingers. Were it not for the pustulous sores on it, a poet might write a sonnet to this hand—the hand that helped to halt the disaster that in the eighteenth century alone wiped out sixty million human beings."

It is of interest that in this same year appeared another publication entitled "Essay on Population" written by an obscure young English curate by the name of Thomas Malthus. And so in 1798 was initiated the first step in preventive medicine which was destined, through lowered death rates and increasing population densities, to lead, a century and more later, to a renewed interest in the doctrines of Malthus and to stimulate the organization of societies for birth control, planned parenthood and the like.

Of Jenner's Inquiry it was later said: "No book so small has been talked of so much; no book has been read from the original so little; no book of such dimensions has made the name of any author so famous." (Sir Benjamin Ward Richardson). It was admittedly incomplete, both in evidence and in description, and the number of experiments was also small. Nevertheless, it quickly went into several editions and was translated into many languages. Jenner became almost overnight a famous figure. Within a year vaccine lymph was in use in Vienna, in Switzerland, Germany, Poland, Italy, Constantinople, in India and in fact throughout the world. His correspondence became prodigious, his practice was neglected, and, as he said, he had become "the vaccine clerk of the world." Because of his financial sacrifices he was persuaded, in March of 1802, to petition Parliament for pecuniary recompense. After considerable debate he was given a grant of 10,000 pounds. The vote to do this was 59 to 56, but it should be added, that the fifty-six minority votes were to give him 20,000 pounds, instead of the 10,000. Again, in 1807, Parliament voted him another grant of 20,000 pounds.

Other honors came to him, and from many places, diplomas, medals, honorary degrees, statues, institutes, etc. Indeed it has been said, "that he attained an influence throughout the world probably never before or since acquired by a private individual." For example, Napoleon quickly recognized the value of his discovery and utilized it in the French army; and in 1804 he presented Jenner with a gold medal. Later, when two young Englishmen were imprisoned in France and efforts to release them had proved unavailing, the parents of the two men asked Jenner to intercede with Napoleon, which he did.

"Sire: Providence has permitted me to make a discovery whose benefits are recognized by all nations. I dare to use this as an excuse to demand humbly a favor of your majesty, who early appreciated the importance of vaccination and encouraged its application; your majesty being universally recognized as a patron of science. My humble request is that you will permit two of my friends, Dr. Wickham and Mr. Williams to return to England. If your majesty will deign to grant my prayer, you will fill my soul with continued sentiments of gratitude. I am, etc." When Napoleon received this missive in Italy he immediately ordered the release of the men with the remark, "Ah, that man, we can deny him nothing."

Before ending these brief remarks about Jenner's contributions to smallpox, something should be said about two of his other scientific contributions—one responsible for his election to the

Royal Society, and one transmitted to posterity, and not properly evaluated for many decades after he had died.

His election to the Royal Society in 1788 came as a result of his studies of the habits of the cuckoo. He was then about 39 years old. Hunter had encouraged him to study the peculiar habit of this bird, namely, that of laying its eggs in other bird's nests rather than building a nest of its own. Jenner dissected many female cuckoos and found that each was capable of laying more than twenty eggs. Later he observed how the young cuckoo pushed its mates out of the nest while the mother bird, no matter of what species, continued to feed the little brute. There must be some philosophical principle to be drawn from this behavioral pattern, but at any rate, it seems odd that we should still use the expression "crazy as a cuckoo."

His other contribution, less well known, was his observation in 1778 of the association between the symptoms of angina pectoris and hardening of the coronary arteries. This discovery worried Jenner greatly because at this time his beloved teacher and friend, the great John Hunter, was exhibiting symptoms of angina. Jenner did not want to tell Hunter about his findings, which came to him in the following way: While performing an autopsy on a patient who had had symptoms of angina pectoris, and while making a transverse section near the base of the heart, Jenner noticed that his knife had struck something hard and gritty. He looked up to the ceiling, which was old and crumbly, thinking that some plaster had fallen, only to discover that the real cause of the grittiness was in the coronary arteries, which had become bony canals. He did not tell Hunter about this but when Hunter died a few years later, his coronary arteries were found to be markedly calcified.

I have already alluded to the interest of President Jefferson in the experiments of Dr. Waterhouse. The interesting chapter of the establishment of vaccination in this country was revealed more clearly some twenty years ago by Dr. Robert Halsey of New York City in a pamphlet entitled, "How the President, Thomas Jefferson, and Doctor Benjamin Waterhouse Established Vaccination as a Public Health Procedure." In searching for and finding the letters written by Dr. Waterhouse in the Library of Congress, Dr. Halsey was able to disclose why Waterhouse needed help and how he got it from the highest quarters.

Waterhouse became convinced of the importance of Jenner's discovery in 1799 when he first received a copy of the famous Inquiry. So impressed was he with it, he immediately reported the method in the Columbian Sentinel under the title, "Something Curious in the Medical Line." At that time Dr. Waterhouse was Professor of Theory and Practice of Physic in the Harvard Medical School. Already he was a controversial figure, partly because of personal idiosyncrasies, partly because he came from Rhode Island, and partly because he was not a graduate of Harvard. Moreover, he was a Quaker, and that was a serious blemish in the Boston of those days. In the article he discussed the differences between smallpox and cowpox and Jenner's discovery of vaccination. In his last paragraph he said, "This imperfect sketch is thrown into the newspaper at this time, with a view of exciting the attention of our dairy farmers to such a distemper among their cows. It may also be gratifying to some of the faculty of medicine, who, it is presumed, are not yet generally informed of an epizootic disease, capable of being communicated from the brute to the human kind, and which, when communicated, is a certain security against the smallpox." Cambridge, March 12, 1799.

Early in the following year he received cowpox "matter" from England and immediately vaccinated his four children, after which he had one son inoculated with smallpox matter in the smallpox hospital near Boston. No smallpox developed and the boy returned home on the twelfth day. As Waterhouse then said, "One fact, in such cases, is worth a thousand arguments." He next wished to spread the knowledge about cowpox in order to accelerate a program of vaccination, and he appealed accordingly to his friend, John Adams, then President of the United States. From the President he got many kind words but apparently very little else. Next he tried to get the Massachusetts Medical Society to take action, but he got little sympathy, perhaps again because of antipathy to him as a person. A member of this society, Dr. John Warren, in writing to his son then in London, said, "The Cow or Kine pox is making some noise here —

I wish you had thought of procuring and sending me some matter as Dr. Waterhouse is the only Physician who has received it from London and has begun to practice and the other physicians can not readily obtain it. John and I would like to know from you what its present character is and if you can easily obtain it and send it in a closely sealed vial. I may possibly have it in that way sooner than any other."

Others heaped calumny upon Waterhouse and endangered his life by threats. For example, an anonymous opponent published the following in a newspaper: "It happens however that sagacity is not quite monopolized, by faculty, and that the public can faintly discern without the assistance of an oculist; which being the case, I am ready to predict, that not only the sensibility of this Philanthropist but his popularity will require both philosophical, and medical aid, to become perfectly hale; and that the practice, with which he commences will silently pilot him back to his native dunghill." Pedro (Columbia Sentinel, September 6, 1800).

Finally, despairing of getting help from President Adams, Dr. Waterhouse turned to Jefferson who was at that time Vice-President and also candidate for the Presidency, running against President Adams. The first letter by Dr. Waterhouse was dated December 1, 1800, and was as follows:

Sir: Having long regarded Mr. Jefferson as one of our most distinguished patriots and philosophers, I conceived that a work which had for its end the good of the community would not be unacceptable to him. Under that impression I have here sent him a prospect of exterminating the smallpox, and am with the utmost consideration and respect, his very humble servt Benj Waterhouse."

To this letter Jefferson replied on December 25, as follows:

"Sir: I received last night, and have read with great satisfaction, your pamphlet on the subject of the kine-pox, and pray you to accept my thanks for the communication of it.

I had before attended to your publication on the subject in the newspapers, and took much interest in the result of the experiments you are making. Every friend of humanity must look with pleasure on this discovery, by which one evil more is withdrawn from the condition of man; and must contemplate the possibility, that future improvements and discoveries may still more and more lessen the catalogue of evils. In this line of proceeding you deserve well of your country; and I pray you accept my portion of the tribute due you, and assurance of high consideration and respect, with which I am, Sir, Your most obedient, humble servant, Thomas Jefferson."

These two lettters initiated a co-operative enterprise on the part of President Jefferson and Dr. Waterhouse covering the year 1801. Several of the later letters describe Jefferson's experiences in the use of vaccinal material sent to him by Dr. Waterhouse and sent by Jefferson, in turn, to physicians in Virginia, Maryland and elsewhere. Because the virus had to be sent on threads and toothpicks, much of it was inert on arrival and numerous attempts at vaccination were unsuccessful. Finally, however, success was achieved, and Jefferson himself vaccinated members of his family and neighbors totalling approximately 200 persons. Moreover, after the vaccinations he had many of them also inoculated with smallpox matter, thus proving that the vaccination was protective against smallpox. Dr. Waterhouse was filled with "pleasure inexpressible" at the success of Jefferson's experiments and in a letter he commented that by Jefferson's influence the "practice of vaccination had been forwarded at least two years."

Some fifteen years later Dr. Waterhouse in a letter to a friend explained why he had turned to Jefferson for help after he had become convinced that he would not get assistance from President Adams in the promotion of vaccination. This letter, written in 1815, told how, in the 1800 campaign for the Presidency, the members of the Harvard faculty were importuned to rally with the clergy and form the front rank of the army of federalism in Massachusetts "in opposition to infidelity, Jacobinism and Jeffersonism." As Waterhouse said, "My associates, and the clergy very generally swallowed and relished this doctrine, while I remained rather silent." Is it surprising that Waterhouse was unpopular with his colleagues?

Another interesting chapter in the development of the cowpox vaccine is that of the opposition to it. Here, as Leikind has pointed out, the printing press was an important instrument, and many pamphlets were published against vaccina-

tion. The causes for the opposition were numerous, probably the most important one being the antagonism of vested interests. Variolation was a lucrative business and vaccination was an invasion of this business. Opposing arguments, moreover, did not operate on an ethical plane, as illustrated by cartoons showing vaccinated children growing horns. A prominent surgeon even advanced a more brutal argument, viz. that "in the populous parts of the Metropolis, where the abundance of children exceeds the means of providing food and raiment for them, this pestilential disease (i.e., small-pox) is considered as a merciful provision on the part of Providence to lessen the burthen of a poor man's family." Others said the data on vaccination were insufficient in that the protection was not permanent, an argument that was obviously valid. Objections on religious grounds were less valid, viz., "that voluntary introduction of disease into the human body was an interference with God's will." Later, compulsory vaccination was looked upon as an infringement upon individual liberty by the State. For these and other reasons antivaccination societies arose and persisted, supported many years later by such individuals as George Bernard Shaw, Alfred Russell Wallace and other well-known figures. Illustrative of some of the opposition is a Report to the House of Commons in 1857, in which it was claimed that "the Compulsory Vaccination Act while dishonoring science invades in the most odious, tyrannical and unexampled manner the liberty of the subject and sanctity of the home; unspeakably degrades the freeborn citizen, not only depriving him of liberty of choice in a personal matter, but even denying him the possession of reason; outrages some of the finest feeling and best affections of the human heart; sets at naught parental authority and responsibility and coerces the parent either to violate his deliberate, cherished, and conscientious convictions, and even his religious scruples."

Despite these opposing points of view vaccination spread throughout the world, and as early as 1803 Sweden passed a law regulating its use. One of the earliest compulsory vaccination acts was in Bavaria in 1807; in 1810 Denmark required it for school attendance and church marriages. It was made compulsory in Russia in 1812, in England in 1840, and in many other countries. It is of interest that in the land of Pasteur it did not become compulsory until 1902.

The problem of transportation of the vaccinia virus to remote places was a formidable one, due to the slowness of ocean travel and consequent loss of the virus. One method was to send children on voyages during which they were vaccinated in series. Thus the King of Spain commissioned three frigates and sent twenty-two children to the New World. Each week two were vaccinated, thus on arrival in Caracas the virus was still active. Some of the children were then taken to South America and others to Central America. One of the ships going to Peru was wrecked but all on board were rescued and it was possible to vaccinate at least 50,000 persons along the Peruvian coast. Other ships went on around the world, carrying the virus to the Philippines, to China, etc. Another series of volunteers carried the virus to India, by arm to arm passage.

In 1842-45, Negri, in Naples, transferred the cowpox virus to the skin of the calf, and soon this procedure became standard in Europe and elsewhere. Today glycerinated calf lymph containing vaccinia virus is the commonly used material for vaccination. In the century which followed the development of this method smallpox practically vanished from the civilized world, at least as a serious killing agent. Also with it the antivaccination societies declined, and now vaccination is compulsory whenever smallpox threatens either the public or military interest.

It is of some interest to compare the methods of evaluation of vaccination against cowpox with those currrently used against poliomyelitis. Despite the fact that inoculation with smallpox matter was hazardous, Jenner's first procedure after he had vaccinated James Phipps was to inoculate him with smallpox virus. Both Dr. Waterhouse and President Jefferson did likewise. So far as I know, however, no one today has had the temerity to inject live poliomyelitis virus following vaccination with the Salk vaccine. Instead, reliance is placed mainly on statistical analysis.

Finally, although we cannot hope that the name of Jenner will occupy a place in history comparable to that of his famous contemporary, Napoleon Bonaparte, who did so much to change the face of Europe and presumably at the same time lower the average stature of French man-

hood. But Jenner at least did not die miserably in exile. Twenty-five years after he had made his great discovery, and while still in the active practice of medicine, he suffered the "stroke" which brought his life to an end.

It is pleasant to recall that in the main his great contribution to humanity was warmly appreciated while he was still alive and that he did not suffer the neglect often accorded contributors to human welfare. It is also pleasant to look back and see how a simple country doctor came so simply to the solution of a great human problem, and by its solution, opened the doors to the vaster problems of sanitation, public health and preventive medicine.

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# New Exchange Resin and Diet in the Treatment of Uremia

By Raimonds J. Gailitis, M.D. and Gerard Hille Ris Lambers, M.D., Chicago

In the past four years an effort has been made to improve the management of uremia associated with hyperpotassemia by combined dietary management and the use of potassium exchange resins.[1,6] The use of intestinal perfusion, peritoneal irrigation, or the artificial kidney is not always a feasible means of management.[14,9] Simple dietary management and potassium ion exchange resins can be used by any physician with a reliable laboratory at his disposal.

As early as 1950 Elkinton[6] tried to exchange an elevated extracellular potassium by means of ammonium carboxylic resins, thus eliminating the danger of high potassium levels on the heart muscle. Borst[13] used another approach in treating patients with hyperpotassemia due to uremia by giving high carbohydrate, high fat, and low protein diets in an effort to increase glyconeogenesis and restoring intracellular potassium. In anuria or oliguria a rising plasma potassium level results from endogenous protein catabolism with transfer of the potassium ion from the intracellular to the extracellular compartment. According to Gamble[10] the average endogenous consumption of protein during the period of fasting is 70 grams a day. This protein catabolism is increased markedly during febrile states, during postpartum involution of the uterus, postoperatively, and following severe trauma to the body. By giving 100 grams of glucose to the fasting patient this endogenous protein catabolism can be reduced to 40 grams per day. An increase of glucose in excess of 100 grams will not bring about further reduction of protein catabolism but will effect greater glyconeogenesis and promote the restoration of potassium into the intracellular compartment.[12]

Potassium is the major basic ion of the intracellular fluid, averaging about 155 mEq per liter, while an average level is about 3.2 to 5.2 mEq per liter in the serum. Gastric juices and small intestine juices have 33 mEq and 5 to 11 mEq per liter respectively.[12] The body of the 70 kg. man contains approximately 3000 mEq (120 grams) of potassium. Most of this is located within the cells with only 60 mEq (2.3 grams) in the extracellular fluid. Normally there exists a constant ratio between intracellular potassium and nitrogen, which is 2.7 mEq of potassium to 1.0 grams of nitrogen (Reifenstein et al).[8] In protoplasm synthesis, potassium moves into the cells at about the same rate that potassium leaves the cells during catabolism. When 40 grams of endogenous protein are broken down as a result of semistarvation, in uremia for example, and the kidneys fail to eliminate the breakdown in the presence of anuria or oliguria, the nonprotein nitrogen increases in increments of at least 6.4 grams a day.[1] Therefore, in the average 70

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kg. man with a total volume of body water of approximately 49 liters, there would be an expected minimal daily increase of the blood urea level of 28 mg. per 100 cc.[1] Since one gram of protein nitrogen is equivalent to 2.7 mEq of potassium,[8] there is a simultaneous release of 17.28 mEq of potassium from the intracellular into the extracellular compartment.

To minimize these changes, a combined treatment consisting of potassium exchange resins and high carbohydrate, high fat, and low protein diet was used by Evans et al in 1952. They used Bull's and Borst's diets which have the following ingredients:

BULL'S I.V. REGIMEN
(Utilized when patient is unable to take oral feedings)

400 grams of glucose in 1000 cc. of distilled water, given by polythene tube introduced into the superior vena cava.

BULL'S ORAL REGIMEN
(Used when patient has no nausea and can tolerate tubal feedings)

400 grams glucose
100 grams peanut oil or olive oil
1000 cc. distilled water

This furnishes about 2,500 calories and is relatively electrolyte free.

BORST'S DIET
(Used when patient is able to take oral feedings)

150 grams of glucose or sucrose
100 grams of custard powder
50 grams casilan (calcium caseinate)
50 grams of butter
1,500 cc. of distilled water

(Electrolyte content of this diet is 7.5 mEq of potassium, 30 mEq calcium)

These dietary measures fulfill two basic purposes: that of protein sparing action and of increasing glyconeogenesis. These measures, however, are not adequate in all instances to reduce high potassium levels. In those cases the potassium exchange resins can be utilized. The first attempt was made by Elkinton et al in 1950,[6] who gave ammonium carboxylic exchange resin both orally and by retention enema which effected satisfactory exchange of potassium ion with a fall in the serum potassium levels. A reduction of from 20 to 73 mEq of potassium occurred daily, and always exceded the amount of sodium removed.

Evans et al[1] reported five cases treated with combined Bull's and Borst's diets with sodium sulfonic resin which contained 90% sodium, 7% ammonium, and 3% calcium. This resin had a binding capacity of 3.4 mEq of cations per gram of resin.[1] When 45 grams of resin were given by the oral route it exchanged from 0.5 to 1.2 mEq of potassium per gram of resin, or a total of 20 to 75 mEq of potassium per day.

## POTASSIUM EXCHANGE USING SODIUM CARBOXYLIC RESIN*

Our experience is limited to potassium exchange using a new sodium carboxylic resin which is charged with the sodium ion in contrast to the ammonium charged, ammonium carboxylic resin which has been described by Elkinton et al. It has several advantages over the previously described resins: (1) The sodium ion is more innocuous than the ammonium ion in uremic patients since ammonia is converted to urea in the liver and the addition of more ammonium ion in the resin would tend to elevate an already high blood urea. By the same mechanism an increased blood urea, which is a neutral cation in comparison to the basic potassium ion which it displaces, would give a consequent increase in an already present acidosis. (2) The sodium ion in the resin is poorly absorbed from the gastrointestinal tract and the only sodium absorbed is most likely that which is exchanged for the potassium ion. This slight increase of sodium ion concentration is negligible as far as altering the over-all sodium level in the extracellular spaces. (Evans et al[1]) (3) The ammonium ion which usually is in high concentration in uremic patients can combine with the sodium carboxylic resin and be excreted by the gastrointestinal tract, thus reducing the level of ammonium containing compounds in the body.[1]

## COMBINED BORST'S DIET AND SODIUM CARBOXYLIC RESIN

The resin was administered orally in four patients in which Borst's diet was used as a vehicle to make about 10% suspension of the resin; 15 grams were given three times a day. The combined use of Borst's diet and sodium carboxylic resin was found to be best suited for the following reasons: (1) The diet is free of or low in undesirable ions such as potassium, ammonium, sodium, or chlorides. (2) It is protein sparing. (3) It increases glyconeogenesis. (4) It furnishes a high caloric diet.

*Sodium Carboxylic resin furnished by Eli Lilly Company, Indianapolis, Indiana

## CASE REPORTS

CASE 1. A. P., a 60 year old white male was hospitalized on March 16, 1954 because of nausea, vomiting, headache, and pain below both costal margins. These symptoms appeared following an ingestion of approximately 15 cc. of furniture polish 10 days prior to hospitalization. The patient had been in good health and had been doing heavy physical work. Despite vomiting, he had passed a normal amount of urine before admission.

Physical examination revealed a well nourished white male, slightly dehydrated, who was complaining of nausea and headache. Blood pressure was 155/88 mm.; pulse rate was 66 and regular; $A_2 = P_2$. Examination of the lungs revealed occasional fine crackling rales in both bases. There was localized epigastric tenderness in the abdomen and both costovertebral angles were tender on pressure.

Urinalysis was negative for albumin, sugar, and acetone but showed a specific gravity of 1.010, a pH of 6.0, 2-4 white cells per hpf, and 1-3 red cells per hpf. The creatinine was 10.0 mg. %, nonprotein nitrogen 133 mg. %, serum potassium 5.6 mEq, and bromsulfalein showed 21.4% retention.

In view of his uremia and the accompanying hyperpotassemia, combined Borst's regimen and sodium carboxylic resin, 15 grams, were given t.i.d. for seven days. The resin was then discontinued because of the weakness experienced by the patient. On the fifth day of treatment the potassium ion level had fallen from 5.6 mEq to 3.8 mEq. Creatinine was 3.1 mg. %, and nonprotein nitrogen was 71 mg. %. Clinically he improved markedly two days after the treatment was instituted and his progress was a rather dramatic one. He continued to put out 1,500 to 2,000 cc. of urine with a fixed specific gravity of 1.010 to 1.012. Routine urinalyses failed to reveal any albumin, casts, or red cells with the exception of the first specimen on admission. His blood pressure ranged between 155/80 mm. to 140/80 mm. and was 145/90 mm. on discharge.

On the ninth day of hospitalization his creatinine was 2.3 mg. % and his nonprotein nitrogen was 46 mg. %. A Mosenthal test revealed a fixed specific gravity ranging between 1.010 and 1.012. He was now symptom free. On the 13th day of hospitalization, seven days following a discontinuation of resin treatment, his serum potassium had gone up to 5.1 mEq. His nonprotein nitrogen, however, was 43 mg. %, with creatinine of 2 mg. %.

He was discharged on the 14th day and has remained in good physical condition and returned to his work.

CASE 2. H. P., a 57 year old male, was hospitalized because of shortness of breath, ankle edema of six weeks' duration accompanied by headaches and polyuria. Neck dissection and laryngectomy had been performed two years previously for carcinoma of the vocal cord. Shortly after this, according to his history, he became ill with acute glomerulonephritis. He appeared to be chronically ill on admission.

Physical examination was essentially negative except for four plus ankle edema and fine crackling rales in both lung bases. His blood pressure was 190/120; pulse 84 and regular; temperature 98 degrees F. Examination of the blood revealed a red count of 3,700,000 and white count of 5,800. Urinalysis showed a specific gravity of 1.016; 40-50 white cells per hpf; four plus albumin. Nonprotein nitrogen was 52 mg. %; total protein 5.71, with 3.20 gm. % albumin and 2.51 gm. % globulin.

The patient's condition improved on a low salt diet and mercurial diuretics. A urinalysis done on the seventh day after admission revealed a specific gravity of 1.015; albumin four plus; 1-3 white cells per hpf; 50-60 red cells per hpf; 10-15 hyaline casts. The red blood count was 4,070,000; the white count 6,900; and there was 90% hemoglobin. Chest X-rays showed evidence of left ventricular enlargement and an electrocardiogram revealed coronary sclerosis.

The patient was permitted to go home, but was readmitted three months later. According to his history he had gotten along fairly well until about six weeks prior to readmission, at which time he noticed loss of appetite, fatigue, and headaches.

Physical examination revealed crackling rales in both lung bases. Only slight ankle edema was noted. Blood pressure was 180/90 mm. Urinalysis showed a specific gravity of 1.008; acetone and sugar negative; albumin four plus; 4-8 white cells per hpf. Red blood count was 3,000,000, white count 7,800, and there was 60.0% hemoglobin. The Kahn was negative. Creatinine was 3.8 mg. %; nonprotein nitrogen was 64 mg. %; blood urea was 41 mg. %; sodium 141 mEq; potassium 5.3 mEq; chlorides 111 mEq. He was given digitoxin, mercurial diuretics, and placed on a low salt diet without any improvement.

In view of his uremia and slight hyperpotassemia, he was given combined Borst's diet and sodium carboxylic resin. The total resin dose prescribed was 60 grams, but due to an error 180 grams were given with a dosage of 15 grams t.i.d. for four days. As a result the patient became lethargic, generally edematous, and weak. Numerous extrasystoles were noted. He developed diarrhea and the fecal material was white and soft having the appearance of the resin which was administered. His blood pressure was 150/76 mm.

He was given 10 grains of potassium chloride, t.i.d., along with orange juice, low salt diet, and 750 cc. of Borst's diet. His condition remained poor for the following two days. Blood chemistry revealed 2.6 mEq of potassium, 154.5 mEq of sodium, 94.9 mEq of chlorides, 33.9 mEq carbon dioxide, 3.2 mg. % creatinine, and 49 mg. % nonprotein nitrogen, showing a decrease in the potassium level with marked sodium retention.

On the sixth day following discontinuation of the resin treatment his condition was markedly improved, and he was up and around. The diarrhea

had ceased, and the calcium was 4.1 mEq, chlorides 106 mEq, carbon dioxide 30 mEq, sodium 143 mEq, and potassium 3.2 mEq. The red count was 2.15 million, white count 6,300, and hemoglobin 53%.

He was given a transfusion of one pint of blood, after which there were 3.24 million red cells, 6,000 white cells, and 70% hemoglobin. On discharge the potassium was 4.4 mEq, creatinine 2.7 mEq, nonprotein nitrogen 63 mg. %, and blood urea 42.5 mg. %. His blood pressure was 150/85 mm. and a Mosenthal test showed a fixed specific gravity of 1.005 to 1.008.

CASE 3. A 53 year old housewife was admitted to the hospital with chief complaints of vomiting for one day, numbness of the right foot for two days, severe headache, and edema of both feet for six months, shortness of breath, and abdominal pressure with nocturia. She thought she had lost eight pounds during the previous eight months.

Other complaints were: flatulence, constipation requiring continuous use of laxatives, hematuria, chills on occasion, pain in the chest, expectoration of whitish-yellow phlegm, restlessness, depression and episodes of dizziness.

Physical examination revealed a well developed, well nourished female who reclined quietly in bed. Her pulse was 88, respirations 32, temperature 98.4°, and blood pressure 240/110. The tongue was dry. The heart revealed a sinus rhythm with tones of good quality and no murmurs. There was enlargement to the left. The lungs were clear. The liver was palpable and moderately tender. No peripheral edema was noted.

Admission clinical laboratory findings were as follows: 3.81 million red cells; 6,800 white cells; 69.2% (10.8 grams) hemoglobin; 88 segmented cells, 9 lymphocytes, 1 monocyte, and 1 stab cell. Specific gravity of the urine was 1.010 with four plus albumin and negative sugar and acetone. There were many white and red cells per hpf. The Kahn test was negative. Blood chemistry showed 6.35 total protein with 3.5 albumin and 2.79 globulin. Urea nitrogen was 64 mg. %, nonprotein nitrogen 145 mg. %, creatinine 2.9 mg. %. The serum sodium was 149 mEq per liter, potassium 4.4 mEq, and carbon dioxide 11 mEq. A cultured catheterized specimen of urine revealed Escherichia coli.

An electrocardiogram revealed a sinus rhythm with slight left heart strain. Hospital care included a low salt, low protein diet with sedation and absolute bed rest. Except for being able to rest more comfortably, her symptoms were unimproved the first six days. She was then placed on the Borst's diet with an additional low salt, low protein meal per day. Her general condition was good and she tolerated the regime well. She had restful nights, although occasionally she experienced headaches. During this period the blood pressure remained around 200/100 mm.

Seven days after instituting the Borst's regime her blood nonprotein nitrogen was 68 mg. %, creatinine was 3 mg. %. Serum sodium was 145 mEq per liter and serum potassium 5.4 mEq per liter. At this time sodium carboxylic resin was prescribed, with a dosage of 15 grams given t.i.d. for six days. Her general condition improved with only a subjective complaint of dizziness on one day of treatment. Occasionally she experienced periods of weakness, but at no time was there any evidence of muscle weakness. Following the sixth day of the carboxylic resin she had 32 mg. % nonprotein nitrogen, 2.3 mg. % creatinine, 4 mEq of potassium. Blood pressure was 220/110 mm. Urinalysis revealed a four plus albumin, 10-20 red cells per hpf, a pH of 7.5, and specific gravity of 1.004. She was clinically improved and arrangements were made for discharge.

Because of a blood count of 3.1 million red cells with 9.8 grams of hemoglobin, a transfusion of whole blood was given which was completed with no untoward effects. During the night she was resting comfortably. At 7:00 a.m. on the next day she was found dead in bed.

Autopsy showed a subacute glomerulonephritis and hypertrophy of the left ventricle. The immediate cause of death was not established.

CASE 4. A 65 year old white female was admitted to the hospital complaining of almost complete loss of eyesight for the last two years, progressive shortness of breath for one and one-half years, anorexia, nausea, vomiting, and weight loss for one year, and generalized weakness for a few months. There were no complaints involving the urinary tract, and past history revealed no kidney disease.

Physical findings on admission revealed the blood pressure to be 205/100 mm. The pulse was 88 with regular sinus rhythm. There was slight cardiac enlargement, fluid in the left pleural cavity, a grade III pitting edema over both tibia, and bilateral retinal detachment.

Laboratory findings on admission were four plus albumin, specific gravity of 1.017, 1-3 white cells per hpf, 2-4 red cells per hpf. There were 8-10 coarsely granular casts per hpf. Blood count showed 2.54 million red cells, 6,800 white cells, 7.5 grams (47.9%) hemoglobin, and a normal differential count. Blood chemistry showed 90 mg. % nonprotein nitrogen, 81 mg. % glucose. Total protein was 6.12 gm. % with 3.58 gm. % albumin, and 2.54 gm. % globulin. The sedimentation rate was 25 mm. in one hour. Plasma electrolytes showed 138 mEq sodium and 5.6 mEq of potassium.

The patient was placed on 1,500 cc. of Borst's diet with 15 grams of sodium carboxylic resin given t.i.d. by mouth. This was supplemented by a low protein breakfast. Seven days later the plasma potassium was 4.4 mEq, and nonprotein nitrogen was 73 mg. %. Two low protein, low salt meals plus 750 cc. of Borst's diet were started on the 7th day. Six days following this regimen the plasma potassium was 4.8 mEq and the sodium 138.5 mEq. The nonprotein nitrogen was 76 mg. %. She was treated with this amount for 15 days.

Her condition improved gradually, with increased appetite and disappearance of her nausea. She had no ankle edema or pleural effusion. She was given Roncovite®* for anemia. Two days before her discharge from the hospital she was digitalized and continued on a daily dose of 0.1 mg. digitoxin. She was advised to continue with her combined Borst's and low protein, low salt diet at home.

For three months following discharge the patient felt well. She then began to experience extreme tiredness, loss of appetite, nausea, and vomiting. On returning to the hospital for a check-up, her blood chemistry showed 82.3% hemoglobin, 4.26 million red cells, 8.5 mg. % creatinine, 139 mg. % nonprotein nitrogen, 95 mg. % urea nitrogen, 12.9 mEq carbon dioxide, 118 mEq chlorides, 5.4 mEq potassium, 4.7 mEq of calcium, and 139 mEq of sodium. Her urinalysis revealed a three plus albumin with 1.006 specific gravity and 7-10 white cells per hpf with fine, granular casts. She was hospitalized immediately.

In view of the azotemia associated with mild hyperpotassemia, the patient was given combined Borst's diet and carboxylic resin for four days. Following this there was a marked reduction in the serum potassium level of 5.4 mEq to 2.8 mEq. Nonprotein nitrogen was reduced to 105 mg. %, creatinine to 7.1 mg. %. She improved clinically and was discharged from the hospital to continue on Borst's diet with low protein, high carbohydrate meals at home, plus Roncovite for her anemia. To date, Roncovite has controlled her anemia during her stay at home.

## COMMENTS

The four cases presented represent patients with kidney and cardiovascular lesions of varying severity:

Case I with chronic nephrosclerosis with a superimposed lower nephron nephrosis apparently precipitated by ingestion of furniture polish.

Case II with chronic glomerulonephritis and congestive heart failure due to hypertensive heart disease.

Case III with subacute glomerulonephritis and severe hypertensive cardiovascular disease.

Case IV with chronic pyelonephritis and hypertensive cardiovascular disease.

All four cases presented hyperpotassemia and high nonprotein nitrogen determinations.

With the exception of case I, all had a rather profound anemia, which one would expect from the chronicity of their kidney lesions.

All cases showed a marked response to the combined therapy of Borst's diet and sodium carboxylic resin.

Case I represented an acute azotemia with a superimposed lower nephron nephrosis, an NPN of 133, creatinine of 10 mg., and potassium of 5.6 mEq. There were no urinary abnormalities and no anemia, which indicated this was an acute and not a chronic uremia. As early as five days following treatment with the combined regimen, the nonprotein nitrogen had fallen to 71 mg. and the potassium to 3.8 mEq, with a concomitant improvement of clinical condition. Following discontinuation of resin therapy the potassium returned to 5.1 mEq, but the nonprotein nitrogen declined to 46 mg.%. Other than a fixed specific gravity of the urine as determined by the Mosenthal test, there were no other abnormalities and the patient returned to his job and has remained asymptomatic.

Case II had chronic glomerulonephritis with a moderate azotemia with nonprotein nitrogen of 64 mg.% and hyperpotassemia of 5.3 mEq. The patient was given the combined Borst's diet and sodium carboxylic resin. Due to an error more than three times the prescribed dose of resin was administered and the patient experienced severe weakness that progressed to semi-coma, ventricular extrasystoles, and diarrhea. There was a concomitant fall in the potassium from 5.3 mEq to 2.6 mEq. The sodium rose from 141 mEq to 154.5 mEq. Resin therapy was discontinued and potassium chloride and orange juice were administered. His condition remained critical for several days, but he gradually improved and was discharged. Potassium and creatinine levels were lower than prior to treatment but there was very little change in blood urea and nonprotein nitrogen levels.

Case III showed marked azotemia and hypertension which was dramatically reduced by the combined diet-resin therapy. After being on Borst's diet alone for seven days the nonprotein nitrogen was reduced from 145 to 68 mg.%, but there was a concomitant rise in the potassium level from 4.4 mEq to 5.4 mEq. Six days after using the sodium carboxylic resin in conjunction with the Borst's diet, the nonprotein nitrogen fell to 32 mg.% and the potassium level was 4 mEq per liter. Clinically the patient felt better than she had for some time. One pint of blood was given the day prior to her contemplated release to correct anemia. Without apparent com-

*Roncovite—Lloyd Brothers Company, Cincinnati, Ohio

plications of the blood transfusion or other demonstrable reason, the patient suddenly expired. Postmortem examination failed to reveal the immediate cause of death.

Case IV. The last case described received the combined regimen twice with a three month interim, with a striking reduction of both nonprotein nitrogen and potassium levels. During the initial treatment the nonprotein nitrogen fell from 90 to 73 mg.%, and potassium from 5.6 to 4.4 mEq after seven days of treatment. Normal red cell count and hemoglobin were maintained with Roncovite. After three months on Borst's diet at home the nonprotein nitrogen rose to 139 mg.% and the potassium to 5.4 mEq per liter. After four days on the combined diet-resin therapy the nonprotein nitrogen fell to 105 mg.% and the potassium to 2.8 mEq per liter. She was discharged the second time symptomatically improved with instructions to follow the Borst's diet supplemented with a low salt, low protein diet at home.

## SUMMARY

Treatment of the uremic state, regardless of the cause, presents problems that are difficult to manage even in the most specialized centers. We have presented a resume of treatment and the case histories of four patients who were treated by Borst's diet and potassium exchange sodium carboxylic resin with rather striking decreases in potassium levels and improvement of their clinical condition.

Potassium exchange, using sodium carboxylic resin, was successful in decreasing elevated serum potassiums as early as the third day after instituting therapy.

The Borst's diet provided a high caloric, low electrolyte means of alimentation, which most patients found palatable. This was supplemented by a high carbohydrate, low protein meal once daily as the condition of the patient permitted a greater intake of food.

Roncovite (iron and cobalt) was a potent bone marrow stimulant in Case IV.

This mode of therapy can be utilized by any physician who has access to a reliable clinical laboratory where accurate electrolyte studies can be obtained. It must be emphasized that the electrolyte status be followed closely and the resin be discontinued as soon as the potassium level reaches 4 mEq per liter or a serious hypopotassemia may result.

Though the reduction of potassium and nonprotein nitrogen levels is not the sole aim in management of uremic patients, there is no doubt that in certain cases this reduction is life saving, and instrumental in decreasing the morbidity of the disease.

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# Can the British Medical Scene Be Transplanted to the United States?

**Hugh A. Johnson, M.D., Rockford**

ONE of the strongest arguments for state medicine is that British medicine is providing more adequate care than is available under the American system; that chaos did not occur when the state took over; and, therefore, we should subscribe to their type of scheme. All too often one reads in the press of a physician who, upon returning from England, gives his opinions regarding the system there. The physician interviewed may have spent only four or five days in England, but his opinion is quoted as valid.

The statements and opinions that follow are based on the following qualifications: I interrupted my training in plastic surgery for three months in 1949 to observe some plastic surgical centers in England. I spent nearly three months going about the country and was so impressed with the type of surgery I saw there, I returned in 1952 to spend nine months working as a trainee in one of the more aggressive plastic surgical centers. My views after the rather hurried three month's trip in 1949 differ markedly from my opinions gleaned during the nine month's stay in 1952 and 1953. All too often one's thoughts are colored by what one wishes to hear. We hear and see only what we want. In 1949 I looked only for faults for I knew that state medicine could not be anything but inadequate. I would like to report my feelings after a year as an integral part of the scheme. I publish this information to be used as argument against the ill advised desires of some who feel that transplantation of the British system would be possible. On the other hand, I would like to be perfectly fair in my reporting and give the British credit where credit is due.

In the watershed of Chicago's newspapers, our feelings are colored by a dominating press. We are enlightened in regard to British medicine only as this press sees fit. During my entire stay in England, I made every effort to question all whom I met about state medicine. This interviewing went from the depths, the charity patients at some of the hospitals and included most of the passengers with whom I was seated on trains and buses. I talked to a few at the top economic level who could well afford to pay and did pay for private medical care.

First, it is difficult to find similar ground on which to base comparison. Sometimes I wonder whether we have anything more in common with the English than the language. To compare similarities between the two countries is equivalent to trying to find similarities between a Texas cowboy and a London banker. Both are men and both are in business but the similarity stops there. The British are a homogeneous people. Their customs and economies do not differ from area to area, nor do they have great regional differences as we do in America. They are inherently honest, and do not consider it clever to find loopholes in income tax laws or padding expense accounts, much as we consider it rather acceptable here. In the military services, we found materials walking off, and the only explanation was that it was expected. In England there was quite a different attitude. The adhesive tape was used thoughtfully, the thought being that the material belonged to Her Majesty's Government, and should not be wasted.

I think that this even carries over into their political life. Most of the career men in the House of Parliament exist on small salaries compared to those of our legislators. The dignity that goes with office is singularly lacking here, and often our sheriff or political appointees are regarded with derision. I think the conception of our "cop" and the average citizen's attitude towards him, often referring to him as a "flatfoot" or other derogatory names when compared with the English "bobby" who is looked up to by all, illustrates graphically a fundamental difference between the two countries. It is the thing that makes the British waiter take pride in his job, and makes him do his best to see that you get the

best service—quite unlike most of our waiters. In the matter of automobile mechanics, I never had any misgivings at any time when taking my automobile to a British garage to have it repaired. I need not draw the comparison with American mechanics I have met.

Secondly, I believe that the average British citizen is inherently polite. Because of this politeness he would not tell you things he knew you did not wish to hear. I am sure we would do the same to an Englishman living in this country. For example, if we realized his favorable attitude toward the royal family, most of us would find it in poor taste to criticize a monarchy in his presence. I feel that most of the doctors over there know that we are strongly against state medicine and are very careful not to offend us. Another factor in evaluating opinions is national pride. Here in the Chicago area we are very proud of our gangsters; they are bigger and tougher than any others. I think the same would go there; they will tell that their bureaucracy is more muddling and clumsy than any in the world.

I have always tried to evaluate the personal motives of the discussant. As one hears the comments in a locker room in the average American hospital, one would think that the government was absolutely stripping most of the men there, for the chief complaints are that taxes are too high, collections are poor, fees too low, and there are not enough paying patients. Similar complaints were voiced in British locker rooms and I believe that this is just a facet of human character.

The dissimilarities between American medicine as it is today and British medicine began long before the World War I. The panel system was developed there and the assigning of panels and the buying and selling of these, removed a good bit of the personal element from a local practice. A man was considered the doctor for a group of patients in an area. When World War II began, England expected that her major centers would be all but completely wiped out in the first period of the war. In anticipation of this they quickly decentralized the medical facilities in London. Outlying country hospitals were transformed into specialty centers. One became an orthopedic hospital, another a neurosurgical, another a plastic center. Then, as the casualties were sorted out in the raids they were sent to the hospital that dealt primarily with their major injury.

As the threat of the raids became less and casualties began returning from overseas this same system of segregation was kept on. In the course of the war every physician went into government employ no matter what his physical condition, so long as he was able to practice. They were told exactly where to go and what to do; there was no personal choice whatsoever. By war's end mobilization had been established for six years. It would have been much more difficult to go back to a system of free enterprise, but merely a step to carry on as they were. Some are quite bitter about this choice and feel that their leaders (the British Medical Association officers) turned the medical profession over to the Labor government for their own gain, perhaps a knighthood. This is not necessarily true, for both the Labor government and the Conservatives were committed by promise to provide a total medical supervisory program. It was merely a question of which party won and working out the details as to how the scheme would be applied.

The change from total mobilization in World War II to a civilian scheme was not difficult. The general practitioner still takes care of his patients as he did during the war years and when a problem is beyond his scope and needs the attention of a specialist, he merely refers it to one of the specialty centers. At the specialty center the senior man with the wider reputation usually has the largest number of cases personally referred. The patient then is given the alternative of waiting his turn to be admitted (perhaps a year and a half) and to see the senior specialist, or of taking one of the younger men with less of a reputation. The patient even has a further freedom, he can go to the specialist of his choice regardless of his location even though he was referred to the regional specialist.

Each practitioner has the right to decide how much time if any, he will devote to the state scheme, and how much he wishes to devote to private practice. In order to maintain a position in one of the teaching hospitals he must spend a minimum of clinic days at the hospital. All of the teaching hospitals are part of the state scheme.

Private work is done in the nursing homes and clinics. The salary that a man receives varies according to the percentage of time he devotes to

state practice. Private practice, however, is rapidly dribbling away to nothing for several reasons. The tax picture is such that private care means sacrifice. State care is at a high enough level that it seems foolish to pay for a room and bed in a hospital in which one can have "free" care.

The British seem to have thought of everything in organizing this scheme, even to motivation. They have established a system of awards, referred to as Merit Awards. These carry a generous yearly stipend for life. These awards are made by committees from each field on the basis of a man's merits and his contributions toward his particular specialty. There are still the incentives of knighthoods and other honors given to certain men within the profession yearly. There is another psychological stimulant in training more men for jobs than there are jobs available. The system becomes highly competitive and men who do not reecive the jobs must either go into general practice in less desirable districts or leave the country.

Who is dissatisfied with the scheme in England? Everyone seems to complain about it, much as they do about the weather but it is hard to find specific reasons for dissatisfaction. Patients complain about long waits for elective surgery, crowded waiting rooms, and the fact that one must pay taxes and not be able to take advantage of the free care because of lack of illness. Similar complaints can be heard in the waiting rooms of any of our larger clinics. British medical students have little to complain of as they are subsidized to about 90 per cent of their expenses. Residents complain about lack of consultant jobs available when they have finished their specialty training, but they are well paid and their working hours are considerably less than that of their American counterparts.

The general practitioner complains loudly and bitterly about overwork and inadequate facilities to allow him to practice the high caliber of medicine he would like to practice. Aside from the accent one could be listening to almost any American general practitioner. Actually in the scheme he is the only man in a position to increase his earnings by taking on more state work. Until recently his pay was disproportionate to the specialist's but this has been remedied. The specialist complains about high taxes and high expenses and lack of well-to-do private patients. These complaints are also familiar to you.

## CONCLUSIONS

The British system of medicine is adequate for England but would be a fiasco if transplanted in America because of the basic differences of economy and culture. Out of fairness to the British, we must admit that their system works for them, but this does not mean that it could possibly work in America. Bearing this conclusion in mind, one is able to counter any argument proposed suggesting that a similar system on a political basis would work in America. Many British doctors feel that their system was foisted upon them by their leaders who saw gain for themselves by turning the British Medical Association over to the Labor government. This is not necessarily true, for all parties in England had committed themselves to some form of state medicine. We must choose our leaders in American medicine with care lest such a thing happen to us.

Gas-Electric Bldg.

# The Spleen

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**Leon O. Jacobson, M.D.,**
**Director Argonne Cancer Research Hospital**
**Aaron Josephson, M.D.,**
**Acting Director, Department of Hematology, Michael Reese Hospital**
**Louis R. Limarzi, M.D.,**
**Assistant Professor of Medicine**

*Doctor Samter*: It is a tradition of the Department of Medicine to hold a seminar on the spleen every two years. In 1956, we have divided the subject into three phases: Dr. Leon Jacobson will discuss the role of the spleen in the formation of cellular elements; Dr. Aaron Josephson, its role in their destruction; and Dr. Limarzi, in conclusion, will outline the clinical implications of the experimental data. Dr. Best has kindly agreed to moderate the symposium.

*Doctor Best*: In 150 A.D., Galen said, "The spleen is an organ of mystery." — I would like to ask Doctor Jacobson to summarize for us the contributions, particularly his own, which have increased, since Galen, our understanding of the physiology of the spleen.

*Doctor Jacobson*: There have been a few times in the past when I thought that I could discuss intelligently the physiology of the spleen; but as of this moment, my position is one of educated confusion, or, perhaps, I should say of learned confusion. The spleen is a difficult organ to study: to name one problem, it shows a marked species variability. In the mouse, for example, ectopic blood formation in the spleen continues after fetal life. Except for the production of lymphocytes, the spleen of the rat, on the other hand, is a poor blood-former. The spleen of the rabbit normally exhibits very little erythro-, granulo-, or megakaryocytopoiesis. The administration of phenylhydrazine will increase hematopoiesis in the spleen of the rabbit by a factor of 10, but even with this increase, the overall production is minimal.

On the basis of my original experiments, I believed that I had demonstrated beyond reasonable doubt the existence of a humoral factor in the spleen that hastened recovery of the blood-forming tissue of irradiated animals. The factor was thought to regulate or provide something that made it possible for irradiated hematopoietic tissue to resume cellular growth. Shielding of the spleen during irradiation of the balance of the body would of course maintain the integrity of such a factor within the shielded spleen as well as prevent damage to the cellular elements in the spleen.

Recently, Ford and co-workers[1], Lindsley, Odell, and Tausche[2], and Newell and his associates[3] have shown by various techniques that the injected cells survive in the irradiated animal and repopulate the hematopoietic system. In point of fact, it has been demonstrated that hematopoietic cells from the rat will repopulate the irradiated mouse and enhance its survival. Similarly, the injection of hematopoietic cells from the mouse will effectively increase the survival of irradiated rabbits. Perhaps we should have anticipated these interesting developments. For several years it has been known that suppression of hematopoietic function and of the capacity to form antibodies in an animal makes it possible to transfer foreign cells that will survive and grow in a host in which such suppression has been effected. For example, leukemia in a certain mouse strain cannot be transferred to another strain of mouse unless the new host is irradiated before the transfer of leukemic cells is made. In this situation, one must assume that irradiation interferes with the natural resistance mechanism that would ordinarily destroy the injected leukemic cells. It has also been known for some time that hu-

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**SEMINAR**
**of the**
**DEPARTMENT OF MEDICINE**
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**UNIVERSITY OF ILLINOIS**
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man cells can adapt slowly in tissue culture to foreign media, e.g., horse serum.

The studies that we and others have done on the inhibition of antibody formation that occurs after irradiation suggest that the recovery from irradiation that has been described briefly may be of both a cellular and humoral nature. The capacity to produce antibodies in irradiated animals can be restored by spleen-shielding, the injection of cells of hematopoietic origin, and, as Jaroslow and Taliaferro[4] have shown, incubation of the antigen with cell-free extracts of spleen before injection.

*Doctor Josephson*: The role of the spleen in the destruction of cellular elements of the blood has received a great deal of attention during the past decade. It is not easy to study the spleen — since its function is not known, it has been difficult, if not impossible, to distinguish pathological from physiological activities. In addition, many of the basic experiments have been done in experimental animals and cannot be immediately applied to man. Fortunately, new investigative techniques, for instance the study of abnormal proteins and of immune mechanisms in hematology, have added a great deal to our knowledge in recent years.

Actually, five physiologic functions have been attributed to the spleen. Of these, the first (1) — hematopoiesis — has been amply covered, and brought up to date by Doctor Jacobsen. The functions of the spleen which are most frequently mentioned are its ability to serve as a reservoir for the cellular elements of the blood and to sequestrate red blood cells. In 1924, Barcroft and Barcroft suggested that the spleen can store and release the formed elements of the blood. It is now quite certain, however, that their conclusions which were based on studies in dogs and cats are not directly applicable to man. In fact, it has been clearly shown that the spleen of normal subjects is of little or no importance as a reservoir organ (Ebert and Stead 1941, Nylin 1947). Wiseman and Doan have suggested that epinephrine contracts and extrudes the cellular elements. Serial testing failed to confirm the original conclusions; and results with splenectomized patients have shown the same or similar results. Doan and others have tried to demonstrate a difference in the quantity of cells in the splenic vein and splenic artery; but their findings have become questionable since refined techniques, particularly the use of syringes coated with silicones, have increased the accuracy of experiments of this type.

(2) The removal of plasma and the concentration and sequestration of red blood cells, on the other hand, through splenic sinus filtration is probably of physiologic importance. Prankerd, Altman, Finch and Gabrio have shown in recent years what happens to erythrocytes which are trapped in the spleen. In hereditary spherocytosis, red blood cells show a deficient glycolysis. If the cells are trapped in the spleen — with concomitant stasis and absence of sugar from the environment — sphering and hemolysis occur. Splenectomy inhibits this process. If one transfuses the blood of the splenectomized patient into a normal non-splenectomized individual, the transfused red cells show a markedly diminished survival time. In other words, the primary defect exists within the erythrocytes — the spleen acts only as a secondary site of destruction, as a graveyard, but is not involved in the etiology of the disease itself.

Until recently, it has not been understood how the spleen can differentiate between normal and sensitized red blood cells of apparently similar morphology and in vitro behavior. Jandl has shown that homologous Rh-positive red cells if sensitized with anti-Rh serum are selectively retained by the spleen of both Rh-negative and Rh-positive individuals. The addition of albumin or other large anisometric molecules to a suspension of sensitized erythrocytes seems to encourage their agglutination. Even though these experiments offer conclusive proof that the spleen can participate in the destruction of red blood cells, such destruction does not seem to be one of its important functions in the normal individual. Splenectomy in a hematologically normal person does not produce a prolongation of the erythrocyte survival time. It does cause changes in the red blood cells, however, which should be briefly discussed. Howell Jolly bodies, Cabot rings, leptocytes and siderocytes appear. Dacie explains the appearance of siderocytes as the result of the loss of a splenic accelerating factor which controls the final stages of the incorporation of iron in the hemoglobin.

4. Jaroslow, B. N. and W. H. Taliaferro. The restoration of hemolysin-forming capacity in X-irradiated rabbits by tissue and yeast preparations. J. Infect. Dis. 98:75 (1956).

Crosby, on the other hand, feels that the spleen is able to filter selectively red blood cells with shape abnormalities from the blood stream. Crosby based his conclusions on studies of the rate of disappearance of siderocytic granules after transfusion of siderocytes into a normal individual; and rather elaborate studies of the retention of Cr51 labelled erythrocytes in the spleen are now in progress.

(4) The phagocytic and reticuloendothelial function of the spleen includes not only red blood cells, but foreign bodies such as India ink, parasites, effete or dead cells and cell fragments which are removed and digested by the splenic macrophages and the reticulo-endothelic cells which are part of the splenic sinuses.

The spleen does not apparently destroy active and functioning blood cells under normal conditions. It is true that Doan and his associates maintain that in idiopathic thrombocytopenic purpura (ITP) the spleen may show active phagocytosis of platelets, but the histopathologic evidence is scanty, and the majority of hematologists are unwilling to accept their conclusions. One ought to mention in this respect the interesting findings of Bierman and his co-workers as well as of Weisberger & Heinle who established the role of the lung in the removal of platelets and granulocytes from the circulating blood.

(5) The concept that the spleen has a hormonal function has been proposed mainly by Dameshek and his co-workers. Actually no one has been able to isolate any splenic hormone which will control cellular activity or undo the effect of spenectomy: this, however, might be simply due to the lack of our ability in preparing such an extract. The evidence for the existence of a hormone is derived from the study of spleen and bone marrow in various cytopenic conditions before and after splenectomy. In primary splenic neutropenia, the bone marrow is filled with granulocytes. The granulotopenia is either due to an arrest in the maturation of the granulocytes or to a block in their delivery — a condition which is corrected by removal of the spleen. Another example: in ITP Dameshek and Schwartz have shown an increase in non-functioning megakaryocytes which disappears after splenectomy.

It has been clearly demonstrated that the spleen produces antibodies, e.g., auto-immune substances which can damage the formed elements of the blood. After the damage has been done the spleen might again fulfill its secondary function to remove the damaged cells from the circulation. Certainly, the spleen is not the exclusive site of antibody formation: in auto-immune hemolytic anemia antibody titers may remain unchanged after splenectomy whether or not the hemolytic process is affected. Splenectomy has been recommended in these conditions if the uptake by the spleen of Cr51 tagged red blood cells has been high.

Similarly the presence of anti-platelet antibodies has been demonstrated in ITP (Harrington, Stefannini and others). The spleen is involved, but again its involvement is secondary. Patients who suffer from ITP might have a normal or even high platelet count after splenectomy. If plasma of these patients is injected into normal non-splenectomized individuals, the recipients develop thrombocytopenia or thrombocytopenic purpura. There are many studies under way to clarify the basic pathophysiology of this disease. Techniques for the demonstration of platelet agglutinins, for instance, are continuously improved and refined; and the common finding of a positive Coombs test in these conditions — demonstrated by Evans, Duane, & Fisher — is under investigation.

In summary then, it would seem that the spleen has an important part, usually a secondary role, in cellular destruction. In diseases which are aided by splenectomy, the removal by the spleen of morphological or functionally abnormal cellular elements from the blood can not be considered part of its normal function: it reflects an abnormal "dysplenic" state. It seems important to make this distinction between a simple overactivity which might contraindicate removal of the organ and its dysplenic behavior which would recommend it.

*Doctor Best*: When the clinician comes to regard the problems of the individual patient, there are two recurrent questions concerning the spleen: (1) is it palpable, and (2) should it be removed? The latter question will be discussed by Doctor Limarzi.

*Doctor Limarzi*: Clinical experience has established the value of splenectomy in the treatment of three main types of hematologic diseases:

(1) hemolytic disorders; (2) hemorrhagic diseases associated with thrombocytopenia in the presence of normal or increased numbers of bone marrow megakaryocytes; and (3) hypersplenic states associated with splenomegaly. Although splenectomy is successful in many of these conditions, in none is there a primary disorder of splenic function. Splenectomy is uniformly successful in hereditary spherocytosis. In acquired auto-immune hemolytic anemia, splenectomy has resulted in complete recoveries in less than 30 per cent of the cases. Splenectomy should be performed if blood transfusions and steroids have failed to produce a remission. Relapse can occur at a later date, especially if the Coombs test remains positive. In the hypersplenic hemolytic anemias without antibodies and in certain cases of leukemia and lymphomas with occult type of hemolysin, splenectomy may prove effective.

Splenectomy in idiopathic thrombocytopenic purpura is followed by good results in about 85 per cent of the cases. The administration of steroids in cases of idiopathic thrombocytopenic purpura may produce a remission. In most cases, the remission is of short duration. The steroids have proven useful in the preparation of patients for splenectomy.

Splenectomy is not indicated in the acute cases unless control by blood transfusions and steroids proves ineffective. In children, spontaneous recovery is the rule; thus splenectomy in children should be reserved for cases of uncontrollable bleeding and chronic recurrent purpura. It is our experience that intracranial hemorrhage is more commonly a complication in patients of the older age group. The older the patient, therefore, the less justifiable it is to employ expectant treatment. In secondary thrombocytopenic purpura associated with Boeck's sarcoid, tuberculosis disseminated lupus or gold therapy intoxication splenectomy has at times proven successful.

Splenic neutropenia and pancytopenia associated with active bone marrow and splenomegaly, usually regarded as primary or secondary hypersplenism, have shown a hematologic cure or improvement following splenectomy. In this group are instances of Felty's syndrome, Hodgkin's disease, Gaucher's disease, leukemia, lymphosarcoma, tuberculosis of spleen, Boeck's sarcoid, etc. In Banti's syndrome or congestive splenomegaly, splenectomy alone is rarely successful. For the past several years, we have not performed splenectomy in Banti's syndrome unless a porto-caval or spleno-renal shunt was performed at the same time. In our experience primary hypoplastic anemia without splenomegaly rarely improves following splenectomy. The operation has proven more successful in those cases with a palpable spleen and a moderately active bone marrow. Myelofibrosis with myeloid metaplasia may result in a tremendous spleen. Splenectomy is indicated if the organ becomes a mechanical embarrassment or with the occurrence of marked hypersplenic effects. It should be emphasized that the results of splenectomy can not be predicted in any one case prior to removal of the spleen.

*Doctor Best*: The seminar is now open for discussion. I will take the chairman's prerogative of asking the first question. Doctor Jacobson, in aplastic or aregenerative anemia would you have the temerity to give the patient total body irradiation and then attempt a bone marrow transplant?

*Doctor Jacobson*: No.

*Doctor Walter Wood,* Fellow in Preventive Medicine: Doctor Limarzi, is the predictability of the value of splenectomy as hopeless as you suggest? Did not the Mayo group describe a steroid test recently?

*Doctor Limarzi*: I believe that the effects of splenectomy are, at least in part, predictable. I have indicated the beneficial effects of the removal of the spleen in certain blood disorders. On the other hand, a large clinical experience has played a very important part in our decision as to whether splenectomy is expected to improve the patient's condition. Steroids can not be used as a test to determine the advisability of splenectomy. In a patient with idiopathic thrombocytopenic purpura, there may be little or no rise of the platelets. Yet in the same patient following splenectomy, there may be a good platelet response. In other words, a failure to obtain a rise in the platelet count after steroids cannot be considered a contraindication to splenectomy.

*Doctor Wood*: Doctor Jacobson, I would like to ask a question which, after so much discussion, might sound facetious, but it is meant seriously: do you believe that the spleen *has* a function?

*Doctor Jacobson*: I do not know.

# Anesthetic Management for Maxillofacial Surgery

**Max S. Sadove, M.D., Chicago**

ANESTHESIA for maxillofacial surgery varies, depending upon many factors such as age, whether the case is traumatic, nontraumatic, whether it is elective or an emergency, and whether there are complicating factors such as shock or obstruction of the airway. Since this subject is so broad, it might be wise to deal with that phase having the widest interest: the management of the patient who has a traumatic injury to the maxillofacial area.

In general, local or regional anesthesia is preferable, probably safer than general anesthesia. Where possible, therefore, local or regional anesthesia is the method of choice. However, in a certain percentage of patients, because of the extent of injury, inability on the part of the operator, lack of co-operation on the part of the patient, or similar causes, local anesthesia may be either contraindicated or nonapplicable. Here, general anesthesia may be administered safely and efficiently.

Regardless of the type of anesthesia, a complete history and physical must be performed prior to giving anesthesia. The history should include questioning as to previous operations and anesthetics, drugs, diseases, injuries and accidents. One must avoid a natural tendency to hurry to repair the results of the trauma. It must not be done without a careful evaluation of the patient. A search must be made for evidence of head injury such as fractures, concussion, or hemorrhage. Shock should be corrected prior to surgery. Frequently the only evidence of shock is a slight nervousness, tachycardia, restlessness, and irritation. Head injury is a common complication in these cases. Blood loss may be insidious and the amount often is not appreciated by the surgical team. If it is thought that the emergency is severe enough, the hazard of waiting must be weighed against those of immediate intervention.

Chest and lung injuries occur coincidentally, but little external evidence of any consequence may be present except tachycardia, and nervousness that may be interpreted as shock. This is seen most frequently in steering wheel accidents.

One must be sure that there is no associated abdominal injury. A perforated viscus may be missed because only a slight bruise over an area not complain because of the shock or the more obvious injury in the facial area.

Respiratory obstruction is probably the most hazardous complication that occurs in the traumatic maxillofacial case. Any case showing respiratory difficulty is an emergency and immediate steps must be taken to overcome the obstruction. This may be done by appropriate splinting, traction on the tongue, or external fixation of the jaw. Tracheotomy may be a life-saving procedure when trauma to the maxillofacial area is extensive. These patients may have been unconscious, blood has trickled into the posterior pharyngeal area, and large quantities of blood have been aspirated into the lung. In other instances, aspiration into the bronchi of vomitus has occurred at the time of injury. Careful evaluation as to contamination of the respiratory passages must be made prior to surgery.

## ANESTHETIC PRINCIPLES FOR MAXILLOFACIAL ANESTHESIA

Regardless of the type of anesthesia, the following features are common or desirable to all general anesthesia for maxillofacial surgery:

1. Ideally, there should be little equipment around the face area so that the surgeon may work in a clear, unobstructed field. This is best accomplished by the use of the endotracheal technique. This may be done trans-orally, trans-nasally, or trans-tracheally.

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*Presented before the Section on Eye, Ear, Nose and Throat 115th Annual Meeting, Illinois State Medical Society, Chicago May 18, 1955.*

2. It is desirable to have a sterile field in the area of surgery. Even though it is true that a sterile field cannot be maintained in many instances, attempts should be made to avoid contamination of all types. The endotracheal technique would seem to be ideal for this purpose.

3. The maintenance of a patent airway is an absolute and irrevocable requirement for all anesthesia. In these cases it is frequently difficult to maintain an adequate airway. However, it must be emphasized that no patient should be put to sleep until the airway is assured and guarded. In many instances it is necessary to insert an endotracheal tube "under topical anesthesia" when the patient is awake, prior to starting the actual anesthetic procedure.

4. One should have the ability to aspirate from the nasal and oropharyngeal passages as well as those secretions that have accumulated in the tracheobronchial tree. This means that good suction, aspiration catheters, and an endotracheal tube should be on hand at all times.

5. It would seem as though light planes of anesthesia would be adequate for most work in and around the head and neck. Since muscular relaxation is not required, light planes are not only adequate but desirable. Ethylene, nitrous oxide, and similar weaker agents properly supplemented should be adequate for most of these cases.

6. In many instances, a nonexplosive technique would certainly be desirable so that one can, if desired, utilize such things as electric drills and other equipment in and about the head, as well as cautery. This would be best accomplished by the use of nitrous oxide with suitable supplementation by an intravenous route.

7. It is easy to traumatize an area that has sustained severe damage. Therefore, when the mask is applied to the maxillofacial injury, one must be extremely cautious lest obstruction, bleeding, or infection be caused by this mask. Intubation, using topical anesthesia, is frequently carried out so as to avoid trauma from the mask.

8. Prior to the onset of anesthesia, as little sedation as possible must be used as excess sedation, which is so frequently used in traumatic cases, will potentiate shock. In addition, there is the danger of respiratory depression which may not only potentiate shock but actually endanger life. Since many of these individuals actually do not have pain, narcotics should not be given. When pain is a real problem, narcotics may be given in the minimal doses compatible with the welfare of the patient.

9. During the time the patient is being prepared, blood should be drawn for cross-matching and adequate blood should be on hand prior to surgery. It may not be necessary; occasionally it is life-saving.

10. An adequate infusion system should be started so that transfusions with blood, plasma, or whatever intravenous fluids are necessary may be given with ease. This should be done prior to surgery because once shock has occurred, it then becomes extremely difficult to start an infusion. Where good veins are not easily accessible, cut-downs of the veins should be carried out under local prior to the onset of anesthesia. Large bore needles, approximately 15, 16, or 17 caliber, should be utilized in any case in which shock is a potentiality. It does little good to have blood available and not be able to get it in quickly. A method of putting the blood in under pressure should be available in all cases where hemorrhage or shock is a possibility.

11. Even though sedation may frequently be omitted, the omission of atropine or similar drying agents is usually an error. True, a tachycardia is undesirable, but with small, divided doses given carefully, an adequate amount of of the abdomen may be present and the patient atropine can be administered without the development of too severe tachycardia.

12. No patient should be put to sleep until one is sure that the unconsciousness will not endanger the airway. When some obstruction already exists, the use of intravenous Pentothal® or similar agent must be avoided at all costs. Too frequently secretions in the back of the throat or the trauma itself will be sufficient to cause laryngospasm which may endanger the patient's life. This can be avoided by an adequate topical anesthesia and placement of the tube under slight sedation from various drugs such as Demerol®, Phenergan®, or Nisentil® Pentothal may be used to create a state of sedation, but this must actually be sedation and not a state of sleep. Even this moderately deep sedation may be hazardous.

13. The technique should be of a type so that a rapid emergence may occur once the anesthetic and surgical procedure is terminated. In this way, if the patient is fully awake, he will guard

his own airway and will avoid aspiration of vomitus or secretions. The technique should be utilized which will result in little or no vomiting. Since many of these patients will have intramaxillary wiring or similar procedures, postoperative nausea and vomiting may endanger the entire procedure if not the life of the patient. Prophylactic does of antiemetic drugs would be advantageous in these patients and techniques such as nitrous oxide-pentothal, nitrous oxide-demerol techniques probably will result in the lowest incidence of nausea and vomiting.

## TECHNIQUE

Premedication should consist of mild sedation and an antiemetic drug as well as a drying agent such as atropine or scopolamine. The timing must be carefully evaluated, especially with the drying agent. There is a tendency to utilize the drying agent at the same time as the sedative. The sedative may wisely be given from an hour and one-half to one hour prior to the expected time of induction of anesthesia, while atropine or scopolamine may be given 30 minutes prior to the expected time of anesthesia. Sedation should not approach the range which would cause sleep in cases in which obstruction of the airway is a potential hazard. On arrival in the operating room, infusion should be started with a large needle, preferably with a crystalloid such as glucose and water. One should check to see that the blood is or will be readily available when needed where bleeding is a potentiality or has occurred at the time of accident. No case should be started if the patient still shows evidence of shock unless bleeding is a problem at that time. In patients in shock, bleeding may be controlled at the same time that blood or intravenous fluid is given.

If tracheotomy has already been performed, the patient may be induced with an intravenous basal anesthetic and the tracheotomy tube is connected to an anesthetic machine. Through the tracheotomy tube, nitrous oxide is administered in concentrations adequate to maintain a satisfactory plane of anesthesia. If tracheotomy is not present, the adequacy of the airway must be investigated. No patient may be put to sleep when there is actual danger of failure of the airway once the patient is asleep. If there are secretions in the back of the throat or in the chest, these patients also should not be put to sleep until the airway is guarded by the presence of an endotracheal tube.

A careful technique of topical anesthesia, usually 1% Pontocaine® may be used to anesthetize the lips, gums, tongue, posterior pharynx, and larynx. If the intubation is to be by a nasal route, the nose also is carefully sprayed with a topical anesthetic. The common error in the use of the topical anesthetics is that dosage is not carefully scrutinized and an adequate time is not permitted for the administration of topical anesthesia. One should use a clock and spread the time for the administration of the topical anesthesia into regular intervals for each section of the procedure. A minute and one-half to two minutes after the lips are done, the gums and tongue are anesthetized. Two minutes later, the posterior pharyngeal wall; and three or four minutes later, the larynx. Careful attention should be paid to the amount of agent administered as these drugs are potentially toxic. However, their toxicity may be markedly diminished by utilization of divided small doses at any particular time. Hurrying markedly increases the toxicity of the local anesthetic agents.

Once the topical anesthesia has been administered and a period of approximately three minutes has passed since the last spraying, then the endotracheal tube, with a cuff that has been previously checked, is selected for the case. This tube may then be passed either by the nasal or the oral route. In general, the nasal route in most maxillofacial cases is either mandatory or preferable. In some instances, however, due to deviation or to the trauma of the nose itself, the oral route is necessary. This would depend upon the individual case. Care must be taken in passing the tube through the nose, that bleeding is not started. A thin-walled, well lubricated tube should be used and if the mucosa is boggy, vasoconstrictor drugs may be combined with a topical anesthetic. By careful manipulation, most anesthesiologists can pass the tube into the larynx without the aid of a laryngoscope. It may be necessary to do a nasal intubation utilizing the laryngoscope for guidance and proper placement of the tube. Once the tube is in place, an intravenous anesthetic utilizing such drugs as Demerol®, Surital®, or Pentothal® may be quickly administered through the intravenous tube at a dose adequate to put the patient into a light

sleep state. Where coughing is objectionable, a topical of the larynx may be added to the topical of the upper passages, reinforced by a transtracheal route. One utilizes a 1½ inch 23 gauge needle, passes it through the subcutaneous tissue and crico-thyroid membrane, and instills through this needle approximately ½ to 1 cc. of 1% Pontocaine (tetracaine).

After the patient has been intubated, small divided doses of a basal anesthetic are added quickly to induce the sleep state. The dose is gradually increased until a light plane of anesthesia exists. During this time, the tube is connected to an anesthetic machine having anesthetic concentrations of nitrous oxide (70-80%).

This phase of the problem is confusing to many. There seems to be an extreme hesitancy about using nitrous oxide either adequately and/or correctly. Nitrous oxide should be used in a concentration that will be tolerated adequately by the patient. In no instance should oxygen be reduced below 20%. If the basal anesthetic has reduced respiration, the concentration of nitrous oxide may be reduced from 80% to 75 or 70% and respiration supplemented. However, the more nitrous oxide is diluted, the greater the need for larger and larger doses of the various anesthetics. It must be pointed out that nitrous oxide is a noninjurious agent; it is not toxic to any organ of the body. However, when combined with inadequate oxygen, trouble may occur. Adequacy of ventilation must be assured at all times. It is important not only that the concentration of oxygen and the gases administered be adequate, but that the exchange across the pulmonary barrier be adequate. An attempt should always be made to maintain a nitrous oxide anesthetic with a supplement of some of the basal anesthetic agents rather than create a sleep state from the basal anesthetic and supplement it with nitrous oxide. This is because nitrous oxide is a more easily and quickly removed, a less toxic, and a more easily controlled agent.

The Demerol technique is increasing in popularity and much can be said in its favor. The patient is less likely to buck on the tube and there is less difficulty at the time of removal of the tube. However, a great deal may be said in favor of Pentothal. Probably the best technique would be a combination of these techniques—that is, topical anesthesia to place the tube, Pentothal to create the initial surgical plane of anesthesia, supplemented with nitrous oxide, and carried on with divided doses of Demerol.

Curare or curare-like drugs rarely are needed. However, where marked relaxation of the jaw is desired, these drugs may be given to create marked relaxation. However, they must be used carefully in small divided doses so that respiratory depression does not occur. Probably the ideal drugs for this technique are those like Succinylcholine wherein the degree of relaxation can be fluctuated from moment to moment. Where relaxation is not necessary, curare drugs add nothing to the procedure, if an adequate plane of anesthesia is maintained at all times.

Care must be taken that the cuffed tube is inflated so that bleeding does not occur beyond the cuff into the trachea. It might be advisable also, in positioning the patient, to so place the head and body that blood will tend to gravitate away from the larynx toward the nasopharyngeal area.

If nitrous oxide anesthesia with supplement of some form is utilized the patient can be maintained in an extremely light plane of anesthesia yet adequate for all surgery at hand. The anesthetist must assure himself at all times that the exchange, the color of the blood, the pulse, blood pressure, are adequate. These patients must be watched, as all patients should be, and the drugs administered from moment-to-moment depend upon the observation of the patient. Regardless of the technique selected beforehand, it must not be adhered to if for example, even with a 50-50 nitrous-oxygen mixture the blood is dark. Oxygen should be increased and a diligent search made for the cause of the cyanosis.

As much as possible, the narcotic drugs, and in this we include Pentothal, Surital, and other drugs, should be kept at an absolute minimum. The advantage of drugs such as Nisentil and Demerol, when used as a supplement, is that they may be counteracted by the drug n-allylnormorphine [Nalline®] at the end of the procedure. It must be remembered that the greater the dosage of Pentothal, the longer the patient is likely to sleep in the postoperative course. Once the procedure is ended, the patient should have a careful aspiration of his endotracheal tube

and especially the area of the mouth and nose. Ideally, the tube should be left in place until such time as the patient has full control of his airway. He should be permitted to awake in the operating room where all the techniques and instruments necessary for emergency procedures may be carried out; where this is not possible, certainly in the recovery room. If not in the recovery room, an intern or resident capable of dealing with emergency must remain with the patient until he can respond to commands. In other words, be sure the patient has control of his airway before he is left to the routine care of a surgical floor. If intramaxillary wiring or similar procedures have been utilized, scissors or wire cutters must be on hand as well as a tracheotomy, bronchoscopy, and suction mouth prop or screw. The patient should be placed in bed on his side with the head dependent so that the dangers of vomiting may be minimized. It may be preferable to place a Levine or similar gastrointestinal suction tube into the stomach while the patient is still anesthetized and have suction proceed during the operative procedure. Or the patient may be brought to the operating room with the gastrointestinal tube already functioning. It is preferable to do a prophylactic tracheotomy under elective rather than under emergency conditions, so that if edema exists and respiratory obstruction is feared, a prophylactic tracheotomy should be done. However, this also may be overdone.

In the postoperative period, many of these patients — although they react at the time that the procedure is completed and even respond to the spoken voice — may frequently go back to sleep and become obstructed. They must have continuous adequate nursing care that usually can be given only in a recovery room type of nursing care. The narcotics used in the immediate postoperative period should be absolute minimal and if possible, avoided entirely. Most patients can be adequately cared for by the use of small doses of Demerol of approximately 25 mg. However, the drug should not be given unless it is certain it will not depress to the degree that the patient may have respiratory difficulty. The tendency is to use too large doses of narcotics in the immediate postoperative period.

In the postoperative period one should also keep in mind the importance of the stir-up regimen — that is, deep breathing, the importance of the cough and of minimizing the doses of narcotics. Oral hygiene must be maintained. Aerosol therapy frequently is neglected. The use of oxygen frequently is haphazard. Adequate tracheotomy adapters should be on hand. Equipment for the administration of aerosol and oxygen and for resuscitation also should be on hand until such time as the patient can maintain his own airway and respiration.

## SUMMARY

The problem of maxillofacial surgery is that of adequate maintenance of a sterile field, of a clear field for the surgeon, one under which he can work in an unhurried, uncluttered manner. The induction of anesthesia should ideally be accomplished under topical anesthesia after the patient has been carefully evaluated and declared to be prepared for surgery. Then the ideal anesthetic would be one which would be light enough to create a quiet patient, being assured that the patient is adequately oxygenated at all times and not depressed, that his overall physiology from moment to moment is observed, and that the patient is in a light plane of anesthesia that will respond quickly and quietly once the surgical technique is terminated. Once the surgical technique is terminated, the hazards again occur when the endotracheal tube is removed. The tube should be removed in the operating room and the patient watched until he responds to the spoken voice. Where this is not possible, he may be removed to a recovery room or its substitute for continuous observation until he is no longer in danger from aspiration or from obstruction of the airway.

# Tranquilization and Sedation by the Use of a Combination of Small Doses of Reserpine and Pentobarbital Sodium

N. O. Calloway, Ph. D., M.D., Chicago

STUDIES have shown definitely that there is a potentiating action between reserpine and the barbiturates (1). This has been shown to be a true potentiation and not a disturbance of either detoxification, excretion, or absorption. While previous work had all been done on laboratory animals[1] the present study was an extension of this concept to human beings. There is no doubt that the barbiturates are effective in the sedation of anxiety states. It had been similarly shown that reserpine has a variety of pharmacologic actions, one of which is a tranquilizing effect and sometimes has marked action in anxiety states[5,11] as well as antihypertensive activities. It was of great interest to us to study the use of reserpine and pentobarbital sodium (Nembutal) in combination* in an effort to discern what effect the two drugs together would have in anxiety states and in hypertensive states.

The newer concepts concerning hypertension [2,3,4] and the methods of evaluating antihypertensive drugs made it necessary to carry out a study in which both drugs would be used, as well as a placebo.

## METHOD

Twenty patients suffering from mild anxiety states were used in this study. No attempt was made to classify these patients psychiatrically as to the exact type of anxieties, but in general these anxieties were expressed as insomnia, vague conversion manifestations such as belching, epigastric distress, esophageal distress, abdominal distress, and nervousness. In none of these patients were there any observable organic lesions. A few patients were included in this study who had well-defined essential hypertension; these will be discussed separately. During the study no other medication was used on any of these patients and they were told nothing about the nature of the medicines which they were to receive except that they were to use one capsule of Nembutal, 30 mg., and one tablet of reserpine, 1/4 mg., each evening before retiring.

Our main interest was to observe what effect the drug had in producing sedation. That we judged from the re-establishment of normal sleep and normal sleep patterns. That is, we were interested in noting whether or not these patients who complained of various minor disturbances could be readjusted by the simple medication to a normal sleep pattern and relief of symptoms.

## RESULTS

In 15 of the 20 cases used it was found that the effect of the combination had a more rapid onset than normally is expected of reserpine, and a more lasting one than is normally found with 30 mg. of Nembutal. These 15 patients all stated that they had a delightful sense of normal sleep beginning the first night and that their degree of relief from anxiety, tension, and insomnia increased during the next four to five days, after which there was no noticeable increase in the effect. For example, patients who awakened three to five times during the night and had extreme difficulty in going back to sleep were now found to sleep, with only one or two awakenings, and as time passed at the end of the week were sleeping through the night without any difficulty whatsoever. On the other hand, patients who had complained that they were unable to sleep more than three to five hours during the night found that their sleeping ability was increased in a day or two to eight to ten hours. There were no complaints at all of any patients that they had increased drowsiness during the day.

*From the Medical Associates of Chicago*

*Now available on the market as Nembu-Serpin ®.

The other five patients had various types of response, all of which were in the direction of relief of symptoms. Three of the patients received only partial relief. These patients, however, did report more comfortable existence and alleviation of their anxieties. One patient had increased intestinal contractions and cramps in the abdomen and medication had to be stopped. It was determined, by eliminating first reserpine, that it was the reserpine to which the patient was responding in this untoward manner.

It was found that when a placebo was used in place of the reserpine that the patients received a partial response. For example, six of the patients placed on the Nembutal-reserpine management were placed on placebos. This consisted of a tablet that was identical in appearance with reserpine, but the patients were given the usual dose of Nembutal. It was found that if these patients had already responded to the Nembutal-reserpine combination, they did not realize that the drug had been changed and the symptoms remained unchanged. In one case the patient came in and stated that he no longer was getting the beneficial quieting effect which he had received from the Nembutal and reserpine.

On the other hand, patients started on the Nembutal and placebo had a much less marked effect than those receiving nembutal and reserpine. Eight patients placed on Nembutal and the placebo found that they received only a short period of sedation in the evenings after taking the Nembutal-placebo combination. In no case did these patients receive the prolonged tranquilizing effect which was present with the Nembutal and reserpine. However, when these patients were allowed to remain on the Nembutal-placebo combination for a period of five days to one week they began to develop some increased sedative effect. This took the form of a more prolonged, more normal, and a more pleasant type of sleep.

Eighteen hypertensives were placed on this management to see what effect it would have. It was found that the hypertension, if it were severe—that is, either long-standing or unusually high, showed little response to this type of management that would not be expected from normal regulation of habits and mild sedation. However, in those patients that had a status such as is normally spoken of as vasomotor instability—that is, mild hypertension of 160/108-110 and on rest and relaxation would fall to 130-140/90-100, the effect was much more marked. These patients' pressures would fall rapidly to normotensive levels and would remain throughout the 24 hours. Furthermore, they were much less responsive to their environment, found a great deal of joy in their activity and in their work, and had no effects of drowsiness.

In ten severe hypertensives with blood pressures averaging 220/120, we found that the Nembutal-reserpine combination given four times a day had a marked effect in relieving these blood pressures. The blood pressures fell in the course of 24 to 36 hours to the levels of 170/108 and thereafter declined gradually over a period of the next 8 to 10 days to 160/100.

## INTERPRETATIONS

The effect of Nembutal and reserpine in combination using 30 mg. of Nembutal and ¼ mg. of reserpine definitely has potentiation effect. This effect was primarily in the speed of onset of the sedative and tranquilizing effects of the two drugs used together. The side effects which were observed were very small and very infrequent. Drowsiness was avoided in each case.

There is little doubt that this combination of drugs will find great benefit in the treatment of the simple anxiety states and in many less complicated neuroses. We use the term less complicated here to mean those of such miscellaneous things as impotence in men, constipation in both men and women, frigidity in women, the elimination of extra cardiac systoles, and tremors.

The use of this combination of drugs in hypertension both of moderate and severe types promises success. It would seem from our studies here that the use of this drug combination in adequate quantities, adequate dosages, and for proper duration of time is extremely beneficial. Recently, it has been noted by some investigators that reserpine alone oftentimes did not produce the desired degree of sedation. There are many hypertensives who we do not want to be alert and over responsive. On the other hand we did not see in any case where 30 mg. of Nembutal-placebo combination for a period of five somnolence. One of the most difficult problems

of hypertensive patients ususally is to keep them quiet and to keep them in an attitude of calmness. Using the combination of Nembutal and reserpine it was possible to get these patients to take a nap in the middle of the day and go to bed early in the evening. All of them reported that they had calm and continuous and quiet sleep during the night. In the patients studied here, symptoms such as headache and vertigo completely disappeared.

## SUMMARY AND RECOMMENDATIONS

It is obvious from this report the Nembutal and reserpine in combination bid fair to be quite effective in producing early, smooth, relaxing sedation and tranquility. This effect apparently extends from pure psychiatric problems of anxiety and conversion of the disturbances to the simpler though more difficult problems of hypertension. Further, there is evidence that simple manifestations of more severe anxieties as enumerated above are amenable to the treatment with this combination of drugs.

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## I've stopped smoking!

I have stopped smoking cigarettes. How smug I am. Nobody dislikes me more than me. There are no compensations. My singing voice has improved but then I could not sing a note in key before, so that the only effect of this is that my bathroom voice penetrates more piercingly into the privacy of my musically minded family. My breathing also is freer. Great lumps of lovely fresh air sweep down into the alveoli that have been smoke filled for years. So, also, do large dollops of the metropolitan atmospheric cocktail of diesel oil and smog. My squash rackets has improved of course but I am too old to be still playing the game and the extra effort that I can now put into it must be taxing my coronaries to the limit, and no doubt very shortly to beyond the limit of their endurance. Appreciation of good food and wine is a long forgotten and now renewed delight, particularly to my tailor who has done all that safety and decency permits in the way of letting out and now, with undisguised enthusiasm, is embarking on a new sartorial building program. Actually, this stopping of cigarettes has not been too bad. I have taken the edge off the misery by an occasional cigar. Being inexperienced, I am not always inspired in my selection and if, during one of the inevitable attacks of vertigo which accompany an unfortunate choice I should fall under a bus, I do hope I live long enough to laugh at the clever way in which I have avoided a lung tumor.*In England Now. Lancet, July* 14, 1956.

# Laboratory Aspects of the Diagnosis and Treatment of Fetal Erythroblastosis*

**Kurt Stern, M.D., Chicago**

Immunohematologic tests are essential for diagnosis, prognosis, and therapy of fetal erythroblastosis. Prenatal testing should include:

1. $Rh_o$ (D)-typing of expectant mothers.
2. $Rh_o$ (D)-typing of husbands of $Rh_o$ (D)-negative pregnant women.
3. Antibody screening, early in pregnancy, of $Rh_o$ (D)-negative women with $Rh_o$ (D)-positive husbands.

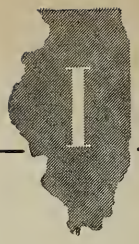
Consideration should be given to the $D^u$ factor in this testing. In the absence of Rh antibodies, the screening should be repeated at 5 and 8 months of gestation. Positive screening tests should be followed by determination of the Rh antibody titer, which is to be repeated at least monthly in the last trimester. Attempts also should be made to determine the zygosity of husbands of women with Rh antibodies. Prognosis for infants of mothers with antibodies is influenced by time of appearance of antibodies; presence of agglutinating or conglutinating antibodies; height of antibody titers; changes in antibody titer; and zygosity for the Rh factor of the father. Definitive diagnosis of fetal erythroblastosis is made on the newborn by means of the following tests: Rh type, Coombs test, RBC, hemoglobin, and serum bilirubin. Latent and manifest disease must be considered and differentiated.

Blood selected for treatment of erythroblastotic infants must be Rh-negative, of an ABO group compatible with infant and mother, and as fresh as possible. Tests helpful for evaluation of efficacy of therapy and of the course of the disease include repeat determinations of Coombs test, hemoglobin, and RBC; nucleated red cell count and reticulocytes; and serum bilirubin. The high correlation between degree of hyperbilirubinemia and propensity to development of nuclear jaundice must be kept in mind. While 95 per cent of cases of fetal erythroblastosis are caused by sensitization of the mother to the $Rh_o$ (D) factor, much more rarely other blood factors may be responsible for isosensitization, e.g., A, B, hr'(c), or Kell. The basic steps for establishing diagnosis of such incompatibilities and resulting immunization were discussed. Methods were outlined for proper selection of blood suitable for transfusion to such infants analogous to erythroblastosis caused by anti-$Rh_o$ (D) antibodies. Also in all other instances the blood used for transfusion of the infant must be free of the antigen which had caused sensitization of the mother.

*Read before the Illinois Association of Blood Banks, 113th Annual Meeting, Illinois State Medical Society, Chicago, May 19, 1953.*

**Abstract of original article.*

# CASE REPORTS



# Fatal Agranulocytosis Due to Chlorpromazine

**Werner Tuteur, M.D., Elgin**

Agranulocytosis remains the most dreaded complication in conjunction with chlorpromazine treatment.

A report to the Council of Pharmacy and Chemistry of the American Medical Association, entitled, "Blood Dyscrasias Associated with Chlorpromazine Therapy,"[1] indicates that by July, 1954, nine cases of blood dyscrasia associated with chlorpromazine had been known. As of January 28, 1956, the date on which the report was published, 45 such cases had been known in the American and British literature.

It had likewise been estimated that approximately four-million people in the United States had been exposed to chlorpromazine. It is roughly implied that possibly one case out of 50,000 to 100,000 patients receiving the drug may develop a dyscrasia.

Seventeen patients who developed agranulocytosis died, but in cases recognized early, recovery generally followed cessation of chlorpromazine administration.

Meanwhile one other case has been described by Carey[2] concerning a 51 year old male who developed agranulocytosis seven days after chlorpromazine had been stopped, going along with a white blood cell count of 350, with no neutrophils present. This patient had been taking 75 to 100 mg. of chlorpromazine daily for approximately two weeks, beginning one month before admission. During admission it had been gradually increased to 400 mg. daily. The patient responded well to antibiotics and after five days neutrophils appeared in the blood. Likewise Barsa and Kline[3] described two cases of agranulocytosis while receiving combined reserpine-chlorpromazine therapy. The two authors postulate that the agranulocytosis in their two cases was due to the chlorpromazine component of the chlorpromazine-reserpine combination. Each concerned a 40 year old white female, and both survived. This brings the total of blood dyscrasias seen in conjunction with chlorpromazine therapy to 48.

The following is an addition of another fatality to the 17 cases so far reported and to the 48 cases known of having developed blood dyscrasias coincident with chlorpromazine. It occurred in one patient out of a total of 1,508 treated (Elgin State Hospital) at this writing.

The patient, A. L., was a 62 year old white female, admitted on August 23, 1946. She had not left the hospital since admission. Prior to

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*Read at the 116th Annual Meeting of the Illinois State Medical Society in Chicago, Illinois, May 16, 1956.*

admission she expressed rather typical paranoid fears and had shown panic states at home, when she would run into the street through traffic. She remained single, and just before her mother died, in 1934 (patient was then 40 years old), she, the mother, revealed to an older brother of the patient that the patient used to masturbate excessively as a young woman. For many years the patient had been supported by the family, and always had been withdrawn. Prior to admission she had become untidy in appearance.

After the father's death, which occurred in 1945, the patient failed rapidly. It was then when her panic states began to appear. She had been living ever since the death of the father with an unmarried brother, who was 59 years of age at the time of her admission. Shouting at the top of her voice, tearing of clothes and pulling her hair were the symptoms precipitating her commitment.

On arrival the patient was well oriented in all three spheres, but showed definite evidence of delusional thinking. A thorough mental examination, performed several weeks after admission, revealed that this patient had been showing evidence of a mild psychosis for many years. She had stopped working at the age of 32, and admitted a "nervous breakdown" at the age of 24. It was obvious that she had been over-devoted to her parents and had no outside interests. Disorganization of thinking was evident, especially in discussing her personal problems. She expressed the delusion that she was married to a man whose name she did not know. A diagnosis of chronic dementia precox, undetermined type, was made. The prognosis was considered poor.

At the beginning of her hospitalization we succeeded in industrializing the patient in the mending room. She was then residing on an industrial ward for elderly women. Signs of occasional irritability, of rage, and the use of vulgar and profane language were observed over the years. Other delusions regarding her food being poisoned likewise became apparent during her course in the hospital. At times she would refuse to eat. Nevertheless, she was satisfied, as the years went by, with a work assignment in the kitchen of one of the infirmaries.

On November 28, 1955, she became extremely noisy and agitated, disturbed other patients, and for this reason was placed on chloropromazine. 100 mg. twice a day. By December 30, 1955, she was reported as quiet and co-operative, performing her work assignment to everybody's satisfaction, and no longer disturbing other patients.

On January 10, 1956, the patient developed a temperature of 103°, giving a history of upper respiratory distress for one week. While initially it was our impression that she was suffering from a virus infection, a blood count performed immediately revealed 3,500,000 erythrocytes, 700 leucocytes, showing a relationship of 94% lymphocytes to 6% granulocytes, and a hemoglobin level of 10.9 mg. Patient was immediately transferred to the hospital, where a careful physical examination did not reveal any necrotizing ulcerations in any of the body openings or on the skin. There were no enlarged lymph nodes. There was a very mild tonsillitis and pharyngitis, showing minimal inflammatory changes. Physical examination was otherwise negative. Her pulse was 88 and respiration was 20. Blood pressure was 130/84.

Chloropromazine was immediately discontinued and she was placed on antibiotics (penicillin, 600,000 units b.i.d., aureomycin, 250 mg. q.i.d., streptomycin, 1 gram, intramuscularly, daily). Other supportive measures were: liver extract, 1 cc i.m., every other day; vitamin B complex, 1 tablet t.i.d. Another blood count taken during the same day revealed 1000 leucocytes with 97% lymphocytes and 3% granulocytes, 3,000,000 erythrocytes and a hemoglobin level of 10.5 mg.

On January 12, 1956, she received 500 cc. of whole blood without ill effects. Her blood pressure at that time was 136/84, and her complete blood count after the transfusion showed the following picture: 1,100 leucocytes with 98% lymphocytes and 2% granulocytes, 3,700,000 erythrocytes and 13.2 mg. of hemoglobin. The following day, January 13th, her leucocyte count was 1600 with 95% lymphocytes and 5% granulocytes.

On January 14, 1956, the patient received another transfusion, consisting of 250 cc. of whole blood. After this her white count was 1500, with 97% lymphocytes and 3% granulocytes. Her R.B.C. was 4,150,000, and hemoglobin 13.5 mg.

Her temperature was 102.2° at 6 a.m. January 14th. While she appeared generally improved

that day, during the early morning hours of the 15th of January, she went into acute cardiac failure, with a heart rate of 140, going along with cyanosis and dyspnea, and a respiratory rate of 34; a few coarse rales were audible over both lungs, and she gave the impression of having beginning pulmonary edema. The patient was immediately digitalized, receiving two ampulse of Digalen®, which was to be repeated every two hours. However, at 6:35 of the same morning she expired. No cortisone had been given.

A case of a 62 year old white female developing fatal agranulocytosis concomitant with chlorpromazine therapy is described. The case is interesting from several aspects. The absence of any necrotizing ulcerations, the absence of any regional enlargement of lymph nodes, of tachycardia, and the presence of only very slight inflammatory changes on tonsils and pharynx label this case as rather atypical.

It has by now become extremely doubtful whether patients suffering from agranulocytosis should receive blood transfusions. In our particular case the possibility exists that acute heart failure might have been the result of the transfusions this patient had received.

Regarding prevention, it is felt that complete blood counts, performed at regular intervals are of little value. Hoch[4] feels there is no dependable laboratory procedure for agranulocytosis which can be given sporadically and the performance of daily blood counts on every patient on chlorpromazine, for practical purposes, is impossible. He, therefore, feels that better methods are necessary to improve the particular compounds causing agranulocytosis, including chlorpromazine. Meanwhile, only most intensive vigilance may avoid this complication. This is most difficult in atypical cases such as this.


**SUMMARY**

1. One case out of 1,508 patients treated with chlorpromazine at Elgin State Hospital developed fatal agranulocytosis. This is the only dyscrasia, as well as fatality seen in connection with chlorpromazine at Elgin State Hospital.

2. The patient had not shown any typical necrotizing ulceration during her course of illness.

3. Blood transfusions in cases of agranulocytosis seem contraindicated, since they might cause cardiac failure. The emphasis of the treatment should be on the antibiotic regimen and possibly cortisone.

4. The case brings the total of blood dyscrasias described in connection with chlorpromazine in the English and American Literature to 49, and the fatalities encountered to 18.


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## Decline in stomach cancer

In both sexes there has been a sizable reduction in mortality from cancer of the digestive tract, especially of the stomach. The reasons for this favorable trend are obscure. While some progress has been made in the surgical treatment of stomach cancer, this probably is not a major factor, because only a relatively small proportion of the cases are caught early enough for treatment to be sucessful. It appears more likely that the recorded decline in mortality represents, in part, the generally increased accuracy in diagnosis and reporting, with fewer deaths being attributed to cancer of the stomach; in part, the decline may reflect a real decrease in the frequency of stomach cancer. *Cancer in Midlife. Statis. Bull. Met. Life. June* 1956.

# Carcinoma of a Duplicated Gall Bladder

S. W. Raymond, M.D., F.A.C.S., Chicago and Chester B. Thrift, M.D., Oak Park

A DUPLICATE gall bladder is rare. More unusual is to have carcinoma in one gall bladder and not in the other. Such a condition has not been recorded in recent literature. Additional complications in this patient were herpes zoster and severe collapse, probably due to having received cortisone about four months previous to surgery.

F.H., a white spinster, 53 years old, was admitted to West Suburban Hospital May 28, 1955, with painless jaundice and pruritus. She stated her stools had varied in color from clay to dark and her urine had been dark amber. There was malaise but no other complaints. She had been treated for anemia and low blood pressure for six months but denied parenteral treatment of any kind. Two weeks prior to the jaundice, diarrhea had existed for several days. She had been exposed to viral hepatitis one week before she became ill.

She was a well developed white female, not appearing acutely ill but showing jaundice. Temperature, pulse, and respiration were normal. Admission laboratory work showed bile in the urine and negative urobilinogen; this finding later became positive. The specific gravity was 1.005. The stools were reported as brown by both laboratory and nurses; they contained four plus occult blood. Blood findings were normal except for 77% segmented neutrophils. Her Van den Bergh showed a delayed positive direct and a positive indirect. Alkaline phosphatase was 24.9, and phosphorus 5.1. On June 2, 1955 the icterus index was 68. June 6, it was 92, and on June 9, it was 109. June 11, 1955 the alkaline phosphatase was 30, bilirubin 13. mg., thymol turbidity 6.8 and phosphorus 5.4 On June 13, 1955 cephalin flocculation was one plus, Van den Bergh was negative for direct and positive for indirect, her icterus index had dropped to 46, prothrombin time was 115% of normal. June 17, 1955 the icterus index had dropped to 29. The liver was palpable four fingers breadth below the right costal margin; it was soft and not tender.

She had a history of left pulmonary pathology. X-rays showed an old calcified tuberculosis at the apex, with pleural effusion and pulmonary fibrosis. Scout films of the abdomen were normal.

Treatment on admission consisted of Vitamin B and a high protein diet with small amounts of saline cathartics and bile salts. June 9, 1955 cortisone was started at the rate of 100.0 mg. per day for three days, dropping to 75.0 mg. per day for two days. Her course showed a progressive rise of clinical jaundice until cortisone was started at which time there was a rapid drop. She was discharged from the hospital June 17, 1955, after 20 days of hospitalization.

Five days after discharge from the hospital, jaundice again appeared. Cortisone was resumed at the rate of 100.0 mg. per day for five days. She complained of backache and the right kidney could be palpated but was not tender. June 30, 1955, a lesion appeared in the region of the backache. It was radicular in distribution and showed the typical blebs of herpes zoster. She stated that the bowel movements varied in color from clay to normal. Visible jaundice had subsided.

She was next seen October 4, 1955, again showing painless jaundice. A diagnosis of "silent" common duct stone was made and operation was advised. At this time she had taken Meticorten® in doses of 10.0 mg. three times a day for three days. After some procrastination, the patient consented to surgery.

## OPERATION

November 1, 1955, under general anesthesia, the abdomen was opened through a subcostal, right sided incision. The liver extended a hand's breadth below the margin; the common hepatic duct was approximately the size of a garden hose

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(2.5 cm.); a mass the size of a distended gall bladder lay between the gall bladder and the liver; the right and left hepatic ducts were greatly dilated. The mass was covered by an "empty" gall bladder with its margins attached by peritoneum to the liver around the "tumor." The common duct below the cystic ducts was normal. The flattened gall bladder, which contained black tar-like bile, was removed from the surface of the "tumor" and amputated through the cystic duct. The "tumor" was next dissected free from the liver down to a point where it likewise had a duct-like attachment to the other hepatic and cystic ducts; there it was removed. The common hepatic duct was next opened and a large T tube, with one limb directed upward and the other downward, was inserted. The dilatation above the point of the cystic duct was due entirely to the extrinsic pressure of the firm mass which later proved to be a gall bladder. The opening into the duct was closed around the tube with interrupted silk. A Penrose drain was brought out through the outer angle of the wound.

The pathologist later identified both removed tissues as containing the structures of gall bladder with chronic cholecystitis in the distal organ and papillary adenocarcinoma in the proximal organ.

Because five months had elapsed since receiving large doses of cortisone and because only a few small doses of Meticorten® had been used during the interval, it was believed it would not be necessary to use these substances either pre- or postoperatively. She left the operating room in good condition and remained so until that evening.

At about 5:00 p.m., considerable bleeding from the wound took place, estimated at about 300 cc. In addition to the 500 cc. of blood she had received in the operating room, another 500 cc. was given. At 3:00 a.m. the dressing again became saturated and her blood pressure dropped to 50 and the pulse was practically imperceptible. Examining the wound, blood-free bile was found to be flowing from around the Penrose drain and through the T tube; blood was oozing from between two of the sutures about midway between the drains. Several sutures were removed and a small skin bleeder was located and ligated. Later, the skin was closed at this point with clips. Fluids were started and cortisone was given by hypodermic.

The patient did not present the typical picture of hemorrhagic shock. The skin was warm, there was no air hunger, she was fully conscious; her only complaint was a feeling of extreme weakness. Her condition gradually improved and 48 hours later her blood pressure stabilized at 110/70. Antibiotics were given to combat sore throat possibly due to the Levine tube or intratracheal anesthesia. Cortisone, interspersed with ACTH, was continued in gradually reduced doses.

## DISCUSSION

Walter S. Snell in *"Disease of the Gall Bladder"* records instances of double and septate gall bladders. Ewing states that 5% of all carcinomata occur in the gall bladder, with women outnumbering men four or five to one, at an average age of 58. Stones are reported to be present in from 70% to 100% of cases in different series; no stones were found in this patient. There is usually a papillomatous outgrowth which may be villous or papillomatous. Gelatinous and diffuse types occur; usually there is extension and metastases at the time of operation and jaundice usually is a permanent finding. This patient had intermittent jaundice; the carcinoma was entirely confined to one of the gall bladders, and no metastases could be found. Cholangiograms to believe that a five year arrest can be expected.

# COOK COUNTY HOSPITAL CASE RECORDS



## Retroperitoneal Rupture of the Duodenum

J. B. Dibble, M.D.*, and Eli T. Samet, M.D.**, Chicago

THE diagnosis of rupture of the second and third portions of the duodenum must be made by inclusion of that diagnosis in the differential diagnosis when an injured person presents symptoms and signs of an acute abdomen, especially when blunt trauma is involved.

Below is presented a case report of a patient who was involved in an automobile accident, and who presented a number of the characteristic findings of this disease.

U. H., a 30 year old, male negro, was admitted on March 3, 1956, with the history that his car had collided with the rear of another auto about eight hours before admission. He had experienced almost immediate pain in the abdomen, most severe on the right side near the umbilicus. The pain continued as a dull ache in the right side of the abdomen and right flank. He vomited one time. There was no other pertinent history related either to this illness or to other illnesses.

Physical examination disclosed a healthy-looking negro male in some acute distress, moving restlessly in bed. The blood pressure was 110/70, the pulse 90, the respirations 20, and the five minute rectal temperature 99.6 degrees Fahrenheit. Examination of the head, neck and chest was entirely normal. There were no scars, cuts, or bruises. The abdomen revealed tenderness of the entire right upper quadrant, with some tenderness in the epigastrium and right lower quadrant. There was splinting of the right rectus muscle and rebound tenderness in the right upper quadrant. Bowel sounds were very hypoactive, but present. The Murphy punch test was positive in the right costo-vertebral angle. Examination of the extremities was negative. Neurological examination was negative.

The positive laboratory findings consisted of a normal hemoglobin (85%), and a negative urinalysis, with no red blood cells being seen on microscopic examination.

A provisional diagnosis of retroperitoneal rupture of the duodenum or retroperitoneal hemorrhage was made, and the patient was prepared for emergency surgery. Under general anesthesia, the patient was explored through a right paramedian incision. In the area lateral to the duodenum, a retroperitoneal collection of bile stained fluid was found. The hepatic flexure of the colon was freed from the duodenum and the duodenum mobilized by the Kocher maneuver. A one and one-half inch ragged perforation of the distal part of the second portion of the duodenum was found. (Figure 1) Repair was accomplished with a double row of interrupted

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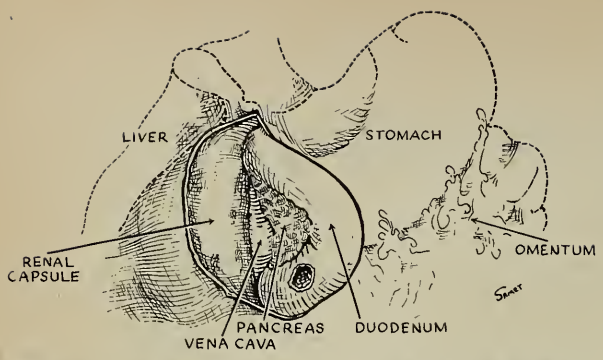



**Figure 1. Schematic drawing of rent in duodenum found at surgery.**

four-aught black silk and a free omental graft tied in over the site. Examination of other abdominal organs was negative for pathology. A Chaffin tube and Penrose drain were placed to Morrison's pouch and the retroperitoneal area, respectively, and brought out through separate stab wounds in the right flank.

The postoperative course was entirely uneventful. The patient was allowed out of bed in a chair on the first postoperative day. The Levin tube with constant gastric suction was discontinued on the third postoperative day, at which time the bowel sounds were normal, flatus was being passed, the abdomen was flat, and the patient felt hungry. A liquid diet was begun on the fourth postoperative day, and gradually increased until by the end of a week the patient was eating a full tray. The drain was removed on the fourth postoperative day and the Chaffin tube on the seventh postoperative day. The postoperative blood amylase was eight units. Sutures were removed on the tenth postoperative day, and the patient discharged entirely asymptomatic on the fifteenth postoperative day.

## DISCUSSION

Importance has been attached by some authors[1,2,3] to the X-ray findings in this disease. The presence of air in the retroperitoneal tissues is practically diagnostic, with extension of air into the peri-renal spaces, into the mesenteries of the large and small bowel, into the mediastinum along the great vessels, and along the psoas muscle to the brim of the pelvis. These findings are undoubtedly of great help in the difficult case which presents with findings other than those of a frank peritonitis. However, if clinical diagnosis of retroperitoneal rupture is made and signs of peritonitis are present, it would seem best to submit the patient to surgery as soon as possible to eliminate the bowel contents and digestive ferments from doing further damage. Even if the exact location of the rupture is in doubt, a long right paramedian exploratory incision can give ample exposure to all quadrants of the abdomen. The picture may be deceptive at the operating table and one must gain a good view of all organs. In this instance, had the duodenum not been completely mobilized, the retroperitoneal tear might have been missed.

In the case, early diagnosis and prompt treatment contributed much to the uneventful postoperative course without complications. A careful closure of the perforation in the duodenum with adequate drainage of the retroperitoneal area is important. These points have been stressed by others.[3] In our case, the differential diagnosis seemed to be limited to retroperitoneal rupture of the duodenum or a retro-peritoneal hematoma. It was our opinion that the evidence of peritonitis, the nature of the tenderness, rebound tenderness, and muscle spasm made it imperative to explore this patient to rule out injuries to the abdominal viscera.

## SUMMARY

A case of retroperitoneal rupture of the duodenum successfully treated is presented.

The indications for surgery are outlined.

The X-ray findings are listed, to be used in the problem case.

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# EDITORIALS




## Chicago physician is GP of the year

Dr. Robert R. Mustell, 63, a family physician whose main practice is in the blighted areas adjacent to Chicago's Loop, has been named by the Illinois State Medical Society as the state's outstanding general practitioner of the year.

This is the first time that the society has so designated a physician with a big city practice. The award has been made annually for the past eight years.

In announcing the selection, Dr. F. Lee Stone, Society president, said the society was particularly appreciative of "the countless hours spent outside his regular practice by Dr. Mustell in organizing, developing, promoting and supervising the Doctors Emergency Medical Service of the Chicago Medical Society over the past five years."

"The service has handled about 20,000 emergency cases since its inception in 1951," Dr. Stone said. "In effect, it is a collective family doctor for thousands of city dwellers who, for one reason or another, have no one to call on in critical medical situations. Dr. Mustell and the 250 volunteer physicians who make the service possible are doing a magnificent job."

Dr. Mustell has been practicing medicine for 37 years. Since 1930 he has maintained an office in downtown Chicago at 30 N. Michigan Ave. This is a central location from which he can most easily reach his patients, whose homes fan out through the Bronzeville district on the South Side and the heterogeneous population areas on the near West and near North Sides. He also is available for emergency medical care to patients in the Loop office buildings.

"The families in my neighborhood have changed completely in the past 10 years, but the medical problems are the same," he observes. "The vast population shift I have seen since the 1920s has siphoned out of these areas many good general practitioners who have not been replaced, although the number of residents has increased."

Dr. Mustell estimates that he sees about 4,000 patients a year in his regular practice. Despite the population change in his "neighborhood," one of the families wrote that he had been their doctor for 33 years. The letter continued:

"During this time he has delivered our babies, daughters, granddaughters and grandson. He has treated us medically and surgically, all of us. We consider him a part of the family and we hope he lives forever."

The son of an adventurous English flour-miller, who later became a prosperous fruit-grower, Dr. Mustell was born Sept. 7, 1893 at Cashmere, Washington. He received his pre-medical education at Washington State College and his M.D. degree at the University of Illinois in 1919. During his last year at medical school, he served a voluntary internship at Mercy Hospital and the Chicago Maternity Center. He opened his first office on Chicago's South Side late in 1919.



**Dr. Robert R. Mustell**

Currently a staff member of the Illinois Central and Chicago hospitals, he has also served on the staffs of Mercy, Columbus and Kenner hospitals. Besides his chairmanship of the local society's emergency service committee, he is a member of its grievance committee and its Council Advisory Committee on Medical Agencies. He also represents the Chicago Medical Society on the Mayor's Committee on Ambulances.

As medical director of the Catholic Youth Organization since 1944, Dr. Mustell initiated a program for C.Y.O. boxers which gives the ringside physician complete control of the fighters and protects the amateurs against permanent injury.

In 1917, during his junior year at medical school, Dr. Mustell married Aileen Gates, an instructor in surgical techniques and the daughter of a manufacturer of commercial chemicals. They have eight children, five sons and three daughters, and 12 grandchildren. Three of the younger Mustells are in show business, one is a building contractor, another an aeronautical designer, the sixth an atomic research specialist preparing for a medical career, the seventh a chemistry student retired from show business, and the youngest is in the Navy.

Since only one of the daughters still lives with them, the Mustells now make their home in an apartment at 1300 N. State Parkway.

The doctor finds city practice as a family physician very much like that of his country counterpart, except for the traffic congestion. He is physician, surgeon, father confessor and family advisor. Of his more than 2,000 operations, a number have been of the emergency "kitchen table" variety. Of the more than 1,000 infants he has brought into the world, many were delivered in the home, and even a few in his car.

One of his more interesting obstetrical experiences was a 2 a.m. delivery of a premature baby several years ago. The only source of heat in the shabby home was a coal-burning kitchen range. He placed the infant in the oven, while he prepared a shoe box with cotton padding in which to transport the child to a hospital. As he describes it, "mother and son made an uneventful recovery."

Two years ago, after 35 years of round-the-clock practice, Dr. Mustell decided to cut down his work load by eliminating night calls. He finds, however, that he still has to scramble out of bed to settle an occasional medico-legal problem connected with the emergency medical service.

Generally, his work day begins at 7 a.m. and ends about 6 p.m. He devotes the first two hours to surgical schedules. He has office hours five days a week from 9 a.m. to 12 noon, and on three of those days additional office hours from 4 to 5:30 p.m. He makes his house calls during the remainder of the time, allowing himself only 15 minutes for a luncheon snack of coffee and rolls or a sandwich.

Even as in the country, Dr. Mustell has telephone communication problems, since many of his patients do not have phones in their homes. To get around this he took on what he describes as "a new look in general practitioners" three years ago. He subscribed to a pocket radio paging service through which he can receive coded messages wherever he goes.

## Medical slang

The vocabulary of physicians contains much jargon. Examples along this line are to refer to a patient as a cardiac, a gall bladder, an acute abdomen, or a cesarean. In addition, the medical profession uses as many abbreviations as does the federal government. We have OB, GC, BP, T and A, VD, and IMS; and the nurse knows that an I.V. does not refer to the ivy league. DOA is dead on arrival and GSW means gunshot wound. Some letter groups have two meanings. B.I.D. can mean twice daily or brought in dead. When you cannot make a diagnosis, GOK (God only knows) comes in handy.

But there is more slang attached to our profession than many of us realize. The American Thesaurus of Slang has nine pages on this subject. Did you know that a hospital orderly is a panhandler and, in some institutions, Coxey's army is the name of the troop of medical students, interns, and nurses that accompanies the chief of staff on his rounds?

Physicians are known as blister mechanics, croakers, pill pushers, and other uncomplimentary titles. A woman physician is a hen medic and surgeons are called everything from butchers to sawbones. The abortionist is a lock picker or pin artist and the obstetrician, a fingersmith, stork doctor, or granny doctor.

Patients are given many colorful names varying from nymphos to multips. The hospital is bedpan alley and drugs are dynamite pills, goof balls, or puff; the new tranquilizers have been dubbed the don't give a damn pills. A cadaver (stiff) is stored in the icebox and the dissecting table is the slab or cold meat block. A small hemostat is a mosquito and the lap sheet covers the laparotomy patient. Gutta percha drain tubes are cigarets and pieces of gauze are flats.

There are many pet names for diseases and deformities. We have the bends, cat fever, and soft bone not to mention cauliflower ear, pigeon breast, saber skin, trick knee, frog belly, goggle eyes, poker back, hobnail liver, policeman's heel, and ragpicker's disease. Most of these terms are well known but did you ever hear that to be immunized is to be salted?

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The food from which a man abstains, after he has eaten heartily, is of more benefit to him than that which he has eaten.

—Luigi Cornaro (1464-1566)

## Illinois physicians should join the World Medical Association

United States Committee members of the World Medical Association have been asked in each state to accept the chairmanship of a committee for the promotion of memberships in their respective states. It has been proposed to break this down further by developing county committees within the respective county medical societies.

Editors of county society bulletins may procure an article from the U. S. Committee, Inc., specially written for a county society publication. All members of the U. S. Committee receive copies of the World Medical Journal which gives much information on medical progress throughout the world.

The annual membership dues are only $10 and the U. S. Committee surely deserves more than the 5,000 American physicians who now support the Committee's work. Dr. Louis H. Bauer, a past president of the A.M.A., is secretary-treasurer of the U. S. Committee, and its chairman is Dr. Austin Smith, editor of the Journal of the American Medical Association.

Physicians who wish to join, or procure information on the work of the U. S. Committee, and the World Medical Association in general, may write to Dr. Bauer, the World Medical Association, 10 Columbus Circle, New York 19, N. Y.

We sincerely hope that many physicians in Illinois will write for an application for membership, and increase the number of members of the World Medical Association in this state.

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## Blue Shield — the "doctors' plan"

All members of the Illinois State Medical Society have recently received one of the Blue Shield plaques which should be displayed in the office. Medical and Surgical Care plans, strictly on a voluntary basis, have grown by leaps and bounds in recent years. This, we believe, has been an important factor in proving that we do not need Federal medical care in this nation.

Blue Shield was initiated by doctors and Medical Societies to help their patients, and its medical policies are determined by medical men.

Hence, Blue Shield is often called the "doctors' plan."

From a public relations standpoint, this has subtle dangers as well as obvious advantages. For while most people will have implicit confidence in a health insurance program approved by the medical profession, there is always the possibility that some may think the "doctors' plan" is designed primarily to benefit the doctor, rather than the patient.

Much depends on the attitude of the individual physician toward his local Plan. If the doctor fails to acknowledge Blue Shield as his own, if he declines to accept the obligations and responsibilities entailed, or if he uses the Blue Shield payment merely as a platform upon which to charge a higher fee, then he should not be surprised if some of his friends conclude that Blue Shield is operated largely for the doctor's benefit.

But if the physician looks upon himself not as the owner but as the trustee of Blue Shield, if he speaks well of the Plan, if he tries to help his patients understand the plan and use it intelligently — then the patient will identify Blue Shield with the idealistic traditions and purposes of medicine.

Blue Shield *is* the "doctors' plan," not in the sense that the doctor owns it, but because he has organized it to help him serve his patients more satisfactorily. It is the "doctors' plan" because the doctor is responsible for it, and because Blue Shield is an impressive proof of the doctors' concern for the welfare of the people.

Blue Shield now serves the vital needs of more than 37 million Americans. Thirty-seven million Americans can't be wrong, and their support of this program represents a tremendous popular vote of confidence in the medical profession. In a sense, Blue Shield is a bond of mutual benefit between the profession and the people.

Your Blue Shield Plan may not be all that you would like it to be, but it is yours — to strengthen and improve. It is the medical profession's best answer — so far — to the challenge confronting the profession, to prove that we can solve our own problems by voluntary cooperation with industry, labor and the public. What Blue Shield may become is largely up to *you!*

## Work starts on Psychiatric Institute State Hospital

Builders began work Oct. 30 on the 11-story Psychiatric Institute State Hospital in Chicago's West Side Medical Center.

The T-shaped structure will cost nearly $8 million. Completely air-conditioned, it will provide facilities for care and treatment of 400 mental patients plus the most modern equipment for research and training activities.

The Illinois Department of Public Welfare,



headed by Dr. Otto L. Bettag, will operate the hospital. A professional board comprised of representatives from the various university medical schools and psychiatric institutes and staff members of the state welfare department will serve as advisers concerning the hospital's professional policies.

Approved by the Council of the Illinois State Medical Society, the project has been praised by representatives of the U. S. Department of Health, Education and Welfare, the Illinois Psychiatric Advisory Council, the American Hospital Association, the Board of Public Welfare Commissioners and the Medical Center Commission.

Plans and specifications were prepared by the firms of Shaw, Metz and Dolio and Fugard, Burt, Wilkinson and Orth as associate architects under direction of Louis H. Gerding, state architect. The building is to be completed in about a year and a half.

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## Gen. Paul I. Robinson to head "Medicare" programs

It was recently announced by the Department of the Army, that Maj. Gen. Paul I. Robinson has been appointed executive director of the new dependent's civilian medical care program. Gen. Robinson will head a program enacted by Con-

gress on June 7, providing for medical care in civilian facilities to dependents of active duty personnel in the "uniformed services".

Gen. Robinson is a native of Illinois and is known to many members of the Illinois State Medical Society. He was born at Mt. Vernon, and attended schools in that city. A graduate of the Washington University Medical School in St. Louis, he received his regular Army commission in August, 1929, and has remained in service since that time.

Gen. Robinson served in the European Theater in 1944 and in 1945 was deputy chief surgeon, U. S. Army Forces, in the Far East. He also saw duty in Korea as the Eighth Army surgeon. He has commanded three of the Army's largest hospitals — Fitzsimons in Denver, Madigan in Tacoma and Letterman in San Francisco.

Since the Army has been designated the Executive Agent for the "Medicare" program, he will be concerned with the arrangement for medical care from civilian sources for the wives and children of personnel in the Army, Navy, Air Force, Public Health Service, Coast and Geodetic Survey and the Coast Guard.

It is stated that approximately 800,000 persons in this category have not received medical care previously because they have not resided near military medical facilities.

The Illinois State Medical Society, at a special meeting of its House of Delegates, August 19, voted unanimously to join in this program. Those who know Gen. Robinson are certain he will do an outstanding job in his new assignment.

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## Anton J. Carlson 1875 . . . . . 1956

One of the nation's foremost physiologists, Dr. Anton J. Carlson, died in Billings Hospital, Chicago, on September 2, 1956. Dr. Carlson was associated with the University of Chicago for 52 years. He was born on a farm in Sweden, Jan. 29, 1875 and his first job was that of a goatherd. At the age of 16 he came to Chicago. where he joined an older brother.

He frequently stated that when he landed, he knew just three words in English — one was "yes", one was "no" and the third, was not printable. Known as "the grand old man of science," Dr. Carlson was a past president of the American Association for the Advancement of Science, and held honorary degrees in medicine, law and science from seven universities and colleges. He received a bachelor's degree from Augustana College in 1898. In 1903 he took his Ph.D. in biology at Leland Stanford University.

As professor of physiology at the University of Chicago, he was known by many members of the medical profession as "Ajax" Carlson. He wrote many books, and published many articles on scientific subjects. Long interested in research, one of his early interests was relative to hunger. He showed that hunger is independent of appetite, and he frequently criticized physicians who insisted on a rigid baby feeding schedule. He said, "feed them when they're hungry."

Dr. Carlson, who lived at 5228 S. Greenwood, Chicago, is survived by his widow, Esther; two sons, Dr. Alvin J., a thoracic surgeon in Dayton, Ohio, and Robert B., and a daughter, Mrs. Alice Hough.

Many thousands of his students, and friends throughout the nation, will long recall his teachings, and will never forget him as one of the greatest scientists of all times.

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## Distinguished service award to Dr. and Mrs. Gibbs

A world-renowned Chicago medical research team, Dr. and Mrs. Frederic A. Gibbs, has been chosen to receive the annual Distinguished Service Award of the Illinois Inter-professional Council, representing 25,000 members engaged in medical practice and allied fields.

Dr. Gibbs, professor of neurology, and his wife, Erna, research assistant in electroencephalography, both on the staff of the University of Illinois College of Medicine, are recognized in medical centers throughout the world as authorities on epilepsy and in the technique for recording the electrical waves from the brain. They have been associated with the university since 1944.

Together they helped organize and staff the Consultation Clinic for Epilepsy at the College of Medicine. They have labored to improve the facilities for treatment of brain-related illnesses and to develop increased potential for research

and teaching in their home state and throughout the nation.

Dr. Edward A. Piszczek, president of the Council, said in announcing the award that the Gibbs team was being recognized "for their dedicated efforts for the betterment of the health and welfare of the people of Illinois through their work."

Harry E. Levin, chairman of the committee which selected Dr. and Mrs. Gibbs from a field of several nominees, said the interprofessional group will present the research team with a plaque at the organization's annual banquet on Dec. 3 in the Congress Hotel.

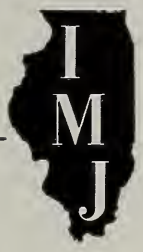
The Illinois Interprofessional Council represents members of the Illinois State Medical Society, Illinois State Dental Society, Illinois Optometric Association, Illinois Chiropody Society, Illinois Pharmaceutical Association and the Illinois State Veterinary Medical Association.

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## A new vasodilator

Choline theophyllinate was tried in 72 ambulatory patients with angina pectoris. Forty-two cases received the drug, while 28 received a placebo. Neither the patient nor the doctor knew whether the drug or the placebo was used (double-blind method). The results proved that in the majority of cases no suggestive influence was involved in the results. No sedative effect was ascertained and tolerance was good. The clinical improvement resulting from the drug was remarkable but gradual in its onset. It was revealed by a decrease in the number of the attacks of pain and in their severity, as well as in the partial or total discontinuance of nitroglycerin. Working capacity and the ability to walk without pain also were increased. The electrocardiogram at rest improved only in a few exceptional cases. The electrocardiogram recorded after a two-step test usually was comparable to that recorded prior to therapy. However, this apparent lack of change was due to the fact that most patients were unable to complete the test before therapy but could complete it afterward. When the number of steps in the test before and after treatment were identical, no changes followed exertion after therapy in some cases, in contrast with the deterioration of the tracing produced by exertion before therapy. This represented objective evidence of the effect of the drug. The mechanism of action of the drug is discussed. It is concluded that the effects are not due to its vasodilating action. Three possible effects are discussed: decreased load on the left ventricle, production of enzymes in the myocardium, or inactivation of pressor amines in the heart muscle. The last two would improve the utilization of oxygen by the heart. However, no conclusion was reached in regard to the action of the drug. *Christ Aravanis, M.D. and Aldo A. Luisada, M.D. Results of Treatment of Angina Pectoris with Choline Theophyllinate. Ann. Int. Med. June* 1956.

# MEDICAL ECONOMICS




## WHAT IKE WANTS IN HEALTH INSURANCE

### PART ONE

*Marion B. Folsom, secretary of health, education and welfare,* told the American Hospital Association (September '56) that the Eisenhower administration will continue to seek legislation for re-insurance funds for improvement in voluntary health insurance.

Folsom said that there are still about sixty million Americans without any form of hospital insurance, seventy-six million without surgical insurance protection, and over one hundred million without general medical coverage.

Since voluntary companies must be encouraged not only to cover the above-mentioned persons, but must be encouraged to broaden their present plans, the government must seek legislation to provide the backing of federal re-insurance. This will speed the further advancement of voluntary health insurance by permitting the risk to experiment and venture into new fields, such as coverage for long term illness, home or office calls, nursing and diagnostic services, and help for the low income groups, older persons, and those in rural areas.

The best comment on this speech was in his conclusion as stated by Folsom himself: "All of us should recognize that the problem of paying for medical care for all the people will yield to no easy or overnight solution. Under voluntary health insurance, progress will stem primarily from the initiative and creative spirit of free enterprise."

### PART TWO

*S. 4172* (introduced by Senators Hill, D. Ala., and Smith, R. N. J.) *H.R. 12140* (introduced by Congressman Thompson D. N. J.) and *H.R. 12153* (introduced by Congressman Priest D. Tenn.) are the administration's measure " to encourage the extension and improvement of voluntary health prepayment plans or policies by permitting pooling."

This is a redraft of the re-insurance scheme. These measures were referred to the Committee on Labor and Public Welfare.

## FEDERAL EMPLOYEE HEALTH INSURANCE

At the last session of Congress, the House Post Office and Civil Service Committee conducted hearings on a proposal for major medical cost insurance of all federal employees. No legislation resulted from the hearings, since Blue Shield, Blue Cross, American Hospital Association, and some labor leaders opposed it. The latter groups wanted payroll deductions to pay for this (employee). The administration wanted federal contributions alone (you and I) to pay for it.

The committee is now making a survey to find the best mechanism to obtain this coverage for federal employees. We hope that we will give them this information, as a group and as individuals. TALK TO YOUR CONGRESSMAN NOW!

In a pre-election campaign speech, Adlai E. Stevenson proposed that federal funds assure comprehensive health insurance for everyone in the United States. He emphasized that there should be no restriction on the individual's freedom to choose his own doctor.

He outlined three major goals:

1. "We must be sure that medical research is not held back by lack of funds."
2. "We must train enough doctors, dentists, nurses, etc. so that all genuine needs for medical care can be met."
3. "We must build enough hospitals and other facilities that all genuine needs for institutional care can be satisfied."

### TOTAL BLUE SHIELD ENROLLMENT IN THE U. S. A

**37,000,000 Americans (June 30, 1956).....**

### THE RISING COST OF MEDICAL CARE

A recent survey by the Bureau of Labor Statistics showed the consumer price index to be 114.9 (1947-49=100). A categorical breakdown showed the food index at 109.6, housing 120.8, apparel 104.8, transportation 126.4, personal care 119.5, reading and recreation 108.2, miscellaneous goods and services 121.4, and at the top, medical care 131.6. This is an all time high for medical care.

One might wonder if this rising cost in medical care is a general one or due specifically to the rising cost of hospitalization, drugs or allied medical services rather than the physician's fee per se. In any event, what are we doing about this inflation?

### HELP FOR THE INDUSTRIAL NURSE

The AMA's booklet "Guiding Principles and Procedures for Industrial Nurses", compiled by the Council on Industrial Health, has proved to be just what the doctor ordered.

### HOSPITAL DRUG STANDARDIZATION

Some hospitals have recently adopted the custom of standardizing drugs. If a certain drug is manufactured by several companies under their different trade names, only one such drug is kept on hand at the hospital. Should you order the drug by a different brand name, the hospital pharmacist uses only the one on hand. In essence, he is permitted to substitute a generic name drug for a brand name drug.

The hospital follows this procedure to save costs, presumably under the direction of the medical staff, through its pharmacy committee.

Is this legal? When drug A is ordered, the pharmacist must fill the prescription only and definitely as ordered. He may choose the brand only when you order the drug by its generic name. What is the policy at your hospital? What is your opinion of this practice?

### "MEDICARE"

What does "Medicare" mean? Are you ready for it? "Medicare" will be in action on December 8, 1956. You had better be informed before that time!

### WISCONSIN LOOKS TO THE FUTURE

The Wisconsin State Medical Society president, Dr. L. O. Simenstad, has called for a look into the future of Blue Shield. "Blue Shield is not only a plan, but a philosophy. There is no turning back," he said. He suggested the establishment of a Blue Shield study program. This should be at local or district levels and coordinated at the state level. He recognizes that Blue Shield plans influence each other because the public thinks of Blue Shield as a nationwide development. Yet problems do vary in different localities.

Certainly this is a step forward. Shall we in Illinois join our neighbor to the north, or shall we let them do all the work?

### SOCIAL SECURITY FOR PHYSICIANS

How much do you know about Social Security? Will you as a physician benefit from this program? Do you want to be "included in" or "included out"?

Read your JAMA for some solid information on Social Security. We hope to present the pros and cons in this column in the near future.

Do your own investigation now. "Investigate before you invest!"

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# THE P. R. PAGE



**Edward A. Uzemack, Director of Public Relations**

WHEN the federal government's "Medicare" plan goes into operation on Dec. 8, the medical profession will have an opportunity to demonstrate its finest public relations manners.

In effect, this is a program that the nation's physicians asked for — a program under which dependents of military personnel will receive medical and hospital care through civilian sources. Public Law 569, the formal title of enactment for "Medicare," is not the ideal solution to the problem, from the profession's viewpoint, but it does represent a big step in the right direction.

For a number of years the profession has complained that the peacetime draft of doctors had been kept alive for the primary purpose of providing medical care for dependents of military personnel. Now the government has set out to make greater use of civilian facilities and it will be up to non-military physicians to prove that they can do the job satisfactorily.

Each state medical society has been asked to designate a fiscal agent to negotiate a working agreement with the government. In addition, the medical societies have been requested to submit a table of fee schedules for use in the program. The government has indicated a willingness to co-operate fully with private physicians in making the "Medicare" program a success.

If every physician will do his utmost to make this plan work, his efforts will reflect favorably upon the profession as a whole.

### WHAT AMERICANS THINK OF THE MEDICAL PROFESSION

Early this year the American Medical Association published a report on what Americans think of the medical profession. It was based on a public opinion survey made by an independent research organization, Ben Gaffin Associates of Chicago.

Personal interviews were conducted with 3,000 members of the general public, 500 physicians in private practice, and 100 persons in each of five special groups — editors, columnists and commentators, lawyers, pharmacists, registered nurses and executive secretaries of state and county medical societies.

In general, results of the survey were heartening and tended to support what informed individuals already believed — most Americans are fond of their personal physicians but hold in lower esteem "other" doctors. It was also found that editors, lawyers and druggists have a less favorable attitude towards the medical profession than does the public. Furthermore, physicians tended to be more critical of their own profession than were the members of the other groups surveyed.

The fact that the vast majority of Americans are fond of their personal physicians indicates

that people primarily appreciate that which they experience through personal contact. When they rely on hearsay their impressions are easily distorted. The public opinion survey would seem to prove that the individual physician's daily contact with his patients is the most important factor in the maintenance of good public relations for the profession.

This business of public relations is a two-way proposition. We get out of it only what we put into it. If all physicians were to become smug over the knowledge that most of their own patients regard them as great guys, we would start moving backwards in the realm of medical public relations.

We know now that there is great need for physicians to promote their colleagues as well as to sell themselves to the public. We also know that one of the biggest jobs before us is the matter of public relations within the profession itself. The survey showed that there are more physicians who have a high regard for the American Dental Association than there are those who think well of their own organization, the A.M.A. It further showed that only half the members of the A.M.A. are active at state and local levels, and only half the members even know how much dues they pay to the A.M.A.

In the past, much of our public relations effort has been of a defensive nature. We have been extremely sensitive to criticism and have developed many of our PR programs as a means of replying to our critics. We have tended to become apologists for the profession; and this is a role that is not becoming to physicians or those who work for them. There is more than enough good in the accomplishments of the profession to give us a base for a positive approach to public relations projects.

The A.M.A.'s report on the public opinion survey, entitled "What Americans Think of the Medical Profession," is an invaluable aid to the planning of any public relations program in medicine. You may still obtain a copy of this report, free of charge, by writing to the Director of Public Relations, Illinois State Medical Society, 185 N. Wabash Avenue, Chicago 1, Illinois.

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## Cardiac rupture

Since cardiac rupture is found in 0.35 per cent of all autopsies and 9 per cent of acute fatal myocardial infarctions, this lesion should not be considered rare as it has been in the past. The success of modern medicine has magnified the field of geriatrics. In turn, myocardial infarction and its complications, including rupture of the heart, are more frequently encountered as the general population advances in age. None of the methods of treatment of myocardial infarction analyzed in the present study could be considered responsible for the recent higher frequency of cardiac rupture. It would be expected, however, that the injudicious use of levarterenol or anticoagulants or the abuse of the bed-and-chair regimen might result in rupture of the heart. A further evaluation of these procedures seems to be indicated. Unlike other complication of myocardial infarcts, the art of prevention seems to be the only solution to the problem of cardiac rupture. Rest must be emphasized during the early period after infarction, when the diagnosis is being established. Hypertensive patients and those who have no evidence of heart failure in particular must be kept at rest if rupture is to be prevented. *John F. Maher, M.D. et al. Rupture of the Heart after Myocardial Infarction. New England J. Med. July* 5, 1956.

# CORRESPONDENCE



## Clinics for crippled children listed for December

Seventeen clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois Division of Services for Crippled Children. The Division will count 10 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing service. There will be 3 special clinics for children with cardiac conditions, 2 for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in co-operation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The December clinics are:

December 4 - Carmi, Carmi Township Hospital

December 5 - Hinsdale, Hinsdale Sanitarium

December 5 - Rock Island (Cerebral Palsy), Foss Home, 3808 - 8th Avenue

December 11 - E. St. Louis, Christian Welfare Hospital

December 11 - Effingham (Rheumatic Fever), St. Anthony's Hospital

December 11 - Peoria, Children's Hospital

December 12 - Alton (Rheumatic Fever), Alton Memorial Hospital

December 13 - Elmhurst (Cardiac), Memorial Hospital of DuPage County

December 13 - Springfield, - St. John's Hospital

December 14 - Chicago Heights (Cardiac), St. James Hospital

December 18 - Peoria, Children's Hospital

December 19 - Elgin, Sherman Hospital

December 19 - Chicago Heights General, St. James Hospital

December 19 - Springfield (Cerebral Palsy), Memorial Hospital

December 20 - Bloomington, (A.M.-General - P.M. - Cerebral Palsy), St. Joseph's Hospital

December 20 - Rockford, St. Anthony's Hospital

December 21 - Chicago Heights (Cardiac), St. James Hospital

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## Alfred A. Schiller memorial fund

The Alfred A. Schiller Memorial Fund which will provide an annual lectureship, is being established at the University of Illinois College of Medicine in honor of Doctor Schiller, Assistant Professor of Physiology, who died unexpectedly in April, 1955. Colleagues and former students may send contributions to the fund in care of Dr. George E. Wakerlin, 1853 W. Polk Street, Chicago 12, Illinois.

## Dr Barth honored

At the Fall meeting of the Board of Chancellors, American College of Radiology, in Los Angeles, September 27-28, Dr. Earl E. Barth was elected Chairman of the Board for 1957.

Dr. Barth, from Chicago, will assume the chairmanship following the midwinter meeting of the Chancellors, February 6 and 7, 1957, at the Drake Hotel in Chicago. He succeeds the retiring Chairman of the Board, .Dr. Earl R. Miller, of San Francisco. At the same Los Angeles meeting, Dr. Fay H. Squire, also of Chicago, was re-elected Treasurer of the College.

Dr. Barth is in the private practice of radiology in Chicago. He is also Professor of Radiology at the Northwestern University Medical School. During the past two years he has served as a member of the Executive Committee of the College Board of Chancellors, and prior to that he had been Treasurer of the College for several years. He has been vice President and Chairman of the Executive Council of the American Roentgen Ray Society, a scientific radiological group, and he served as Treasurer and member of the Executive Committee of the Fifth Inter-American Congress of Radiology in April 1955. He is currently chief consultant in radiology at the VA Research Hospital in Chicago.

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## Postdoctoral fellowships

December 1, is the deadline this calendar year for submitting applications to the National Foundation for Infantile Paralysis for postdoctoral fellowships. Applications submitted before that date will be considered by the appropriate National Foundation Fellowship Committee in February.

Postdoctoral fellowships are available (a) in Rehabilitation, either the concept and basic techniques applied to specialized fields in medicine, or for preparation in the specialty of Physical Medicine and Rehabilitation; (b) in Psychiatry; (c) in Orthopedics; (d) in the Management of Poliomyelitis; (e) in Preventive Medicine; (f) for postdoctoral training in research and/or academic medicine.

In addition to a montly stipend which varies from $3,600 to $6,000 annually according to the individual needs and marital status of the applicant, the National Foundation arranges for compensation to the institution according to the program undertaken. For a full academic program, tuition and fees are paid; for other programs, a sum not to exceed $1,250.00 per year including tuition. Partial fellowships are available for qualified veterans to supplement G. I. educational benefits.

The next deadline for applications will be March 1 for consideration in May.

For further information write: Division of Professional Education National Foundation for Infantile Paralysis 120 Broadway New York City, N. Y.

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## You and your magazine

Doctor, if you have Today's Health in your reception room it means you are practicing a public service called the 3 Rs program — Reception Room Readership — and that is good. If you do not have Today's Health in your office, you are missing the opportunity to inform your patients on matters pertaining to the maintenance of good health in language that they can understand.

A medical man has his medical journals and publications to rely on for help and information, the layman has Today's Health. It is every doctor's responsibility to make this magazine available to his patients, friends and neighbors.

Through this medium of health information, respect for the medical profession and its high standards can be encouraged while quackery and propaganda can be discouraged.

"When was honey ever made from one bee in a hive?" This quotation applies to every one. Doctor we need you and your help in the Today's Health program. Have it in your reception room, give it for Christmas to patients, relatives and friends. Let us follow the advice of the Illinois Auxiliary President, Mrs. Robert E. Dunlevy: "Buy a copy. Give a copy. Sell a copy."

Please contact your County Auxiliary Today's Health chairman, your State chairman or the office of Today's Health, American Medical Association, 535 North Dearborn, Chicago 10, Illinois. For physicians and dentists there are special half-price rates (one year $1.50).

Mrs. Wendell F. Roller
Illinois Today's Health Chairman
Monmouth, Illinois

## Symposium on immunology

A symposium on immunology will be presented by the Milwaukee Academy Of Medicine at Marquette University, Brooks Memorial Union on Saturday, December 1, 1956 - 9:00 a.m. to 4.00 p.m.

The faculty will be Frank J. Dixon, Jr., M. D. Professor and Director, Department of Pathology University of Pittsburgh School of Medicine; T. N. Harris, M. D. Associate Professor of Immunology in Pediatrics University of Pennsylvania; William B. Sherman, M. D. Associate Clinical Professor of Medicine Columbia University College of Physicians and Surgeons; Carl V. Moore, M. D., Dean Washington University School of Medicine; and Theodore L. Squier, M. D. Associate Clinical Professor of Medicine Marquette University School of Medicine

All physicians are welcome to attend and there is no registration fee. Luncheon will be served at the Union. Reservations may be made by writing to the Milwaukee Academy of Medicine, 561 N. 15th Street, Milwakee 3, Wisconsin.

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## Illinois pathologists to meet

The fall meeting of the Illinois Society of Pathologists will be held on December 1 at St. Johns Hospital in Springfield. The program follows:

SLIDE SEMINAR 9:00 a.m. on 12th Floor

Moderator: Grant C. Johnson, M. D., pathologist, Memorial Hospital, Springfield clinical assistant professor of pathology, University of Illinois.

Panel Members: Harold D. Palmer, M. D., pathologist, St. Johns Hospital, Springfield; Paul E. Steiner, M. D., professor of pathology, University of Chicago; Mark C. ology, University of Chicago; Mark C. Wheelock, M.D., pathologist, Passavant Memorial Hospital, Chicago and associate professor of pathology, Northwestern University.

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## The prevalence of tuberculosis sensitivity

Tuberculin sensitivity was studied during 1949-51 in more than 12,000 white men and women 17-21 years of age, by testing with the intermediate (0.0001 mg.) dose of the international standard tuberculin PPD-S. The study population comprised navy recruits from all parts of the country, tested as they entered the Naval Training Center at San Diego, Calif., and students, mostly freshmen, attending colleges and universities in 17 states. Residence histories obtained from each person at the time of the testing provided material for studying geographic differences in the prevalence of tuberculin sensitivity. The average frequency of reactors was 8.8 per cent, corresponding to an annual infection rate of less than five per 1,000 during the last two decades. However, prevalence rates among navy recruits ranged from about 20 per cent in lifetime residents of Arizona and New Mexico to less than 4 per cent in Idaho and Nebraska. Rates in the college students, while generally lower, reflected similar geographic differences. Residents of metropolitan areas generally had higher rates than farm residents. A high positive correlation was found between the frequency of reactors among the navy recruits and tuberculosis death rates in the white populations of their home states. *Carroll E. Palmer, M.D. et al. Tuberculin Sensitivity in Young Adults in the United States. Pub. Health Rep. July* 1956.

# AT THE EDITOR'S DESK



THE October issue of Medical Economics carried its eighth quadrennial survey of the income of physicians. The self-employed radiologist has replaced the neurosurgeon as top money maker; he nets $25,040 annually, or $52 a year more than the neurosurgeon. The orthopedic surgeon, with $24,967, is followed by the plastic surgeon, whose net earnings are $23,050. The survey indicates that the self-employed GP now nets $14,817 while the self-employed specialist nets $18,010. But the typical GP need not be too concerned because he earns more than the typical internist and the self-employed specialist in physical medicine, industrial practice, and pulmonary disease. In this respect, he has passed several specialists in income and may be gaining on others.

The heart conscious physician may be interested to know that the lowest mortality rates for coronary disease among white males of all ages in 1950 was in New Mexico, followed by Arkansas and Kentucky. The highest were in New York, Rhode Island, and the District of Columbia.

A fatal case of listeriosis in an infant was reported by the Connecticut State Department of Health. The child appeared normal at birth but developed fever and rapid respiration on the next day. A chest X-ray showed an area of consolidation in the left upper lobe and a blood culture was positive for Listeria monocytogenes. The mother had no contact with animals, except the family dog, while she was pregnant. A gram-positive motile organism was isolated from the mother's cervix but it has not yet been identified.

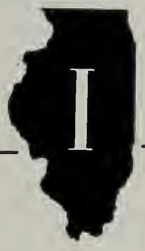
A report in the Canadian Anesthetists' Society Journal states that Demerol and scopolamine produced satisfactory analgesia in obstetrical cases, with less depressant effect on respiration than that given by other drug combinations.

Ciba announced the introduction of a new product — Vioform Hydrocortisone — as a remedy for detergent hands, eczema, and various chronic skin conditions. The preparation is a nontoxic water washable cream.

Many news releases follow a typical pattern such as: "For the first time, millions of Americans can look forward to sure, direct relief of muscular and neuralgic aches and pains without counterirritation or injection, thanks to medical science. . . . . ." The size of the market is mentioned and the claims of the manufacturer are stated in glowing terms. The term, medical science, gives the copy an authentic and a scientific touch. It sounds wonderful but the majority of editors see through such blurbs. This is free advertising, not news, and if they want advertising they ought to direct their correspondence to the proper department.

Sterling Drug Inc. continues to have a major interest in aspirin. This time they recommend "trial with aspirin suggested as first step in cancer pain." Physicians usually start with a simple remedy and a news release of this type backs them up.

# NEWS of the STATE



## ADAMS

**Society News.**—Dr. Gordon Perisho, Quincy, addressed the October 8 meeting of the Adams County Medical Society on "Radioisotopes in Practice."

## COOK

**Courses on Pediatric Cardiology.**—Three intensive postgraduate courses in pediatric cardiology began November 5 for two weeks. They included a one week course in the diagnosis and treatment of congenital and rheumatic heart disease, and two courses of three days each in roentgenology and electrocardiography in heart disease, and in angiocardiography and catheterization of the heart and great vessels. The courses were designed for pediatricians, roentgenologists and internists. They were conducted at Cook County Graduate School of Medicine by Drs. Benjamin M. Gasul and Egbert H. Fell and associates.

**Lasker Award Goes to Dr. Katz.**—The Lasker Award of the American Heart Association has been given to Dr. Louis N. Katz, head of cardiovascular research at Michael Reese Hospital, for "distinguished achievement in the field of cardiovascular research." The award, consisting of $1,000 and a gold statuette, of the Winged Victory of Samothrace, symbolizing victory over death and disease, was to have been presented at the annual convention of the American Heart Association in Cincinnati, October 27.

**Students Honored.**—Seven Northwestern University Medical School students and graduates have been honored for scholastic achievement and research.

Dr. Richard H. Young, dean, presented the awards at a Founders' Day convocation on Tuesday, October 2, in Thorne Hall on the Northwestern Chicago campus. The convocation formally opened the ninety-ninth annual session of the medical school.

The Founders Day address was delivered by Dr. Walter G. Maddock, Elcock professor of surgery. He spoke on "The Medical Student Here and Abroad".

Dr. Billy James Williamson, Hillsboro, Ohio, received the Borden undergraduate research award in medicine. This award of $500 and a certificate is given to a student in the graduating class who performed meritorious medical research while an undergraduate medical student. Dr. Williamson did research work on the effects of various chemicals on kidney function.

Winner of the George J. Dennis Phi Rho Sigma award was Dyrel Alden Faulstick, Los Angeles, Calif., who received a $100 bond for the highest scholastic average for the first three years of medical school.

A certificate of recognition was given to Phi Delta Epsilon as the medical fraternity maintaining the highest scholastic average during the past year. Dr. Joel Brumlik, Chicago, received a $50 bond as the man in the fraternity who contributed most toward winning the award.

Eugene M. Aronow, Passaic, N. J. received the Phi Chi award of $50 and a certificate. This award, named in honor of Dr. James P. Simonds, professor emeritus of pathology, is presented annually to the outstanding junior student who shows clinical achievement and promise.

Winner of the Roche award, given by Hoffmann-LaRoche Inc., for outstanding scholastic attainment during the sophomore year, was Stanley B. Vander Aarde, Orange City, Iowa. Mr. Vander Aarde was given a scroll and an engraved watch.

Jack Paul Startz, San Pedro, Calif., was the recipient of the Phi Beta Pi Leslie B. Arey award, given to the freshman student for the highest scholastic achievement in the study of anatomy. The $50 award has been named in honor of Dr. Leslie B. Arey, professor emeritus of anatomy. The fraternity

also gives $100 to the school's Archibald Church Library each year for the purchase of books for the Leslie B. Arey collection.

**Faculty Promotions.**—The Chicago Medical School has announced the following faculty promotions: Drs. George J. Scheff, from associate professor to professor of Microbiology and Public Health; Abe L. Aaronson, from assistant professor to clinical associate professor of medicine; Martin M. Kirshen, from associate professor to clinical professor of medicine; Meyer J. Steinberg, from assistant professor to clinical associate of medicine; Bernard Chomet, from associate to assistant professor of clinical pathology; Arnold Black, from clinical associate to clinical assistant professor of medicine; Irving A. Friedman, from clinical instructor to clinical assistant professor of medicine; Milton M. Kadin, from clinical associate to clinical assistant professor of medicine; Erwin Kammerling, from clinical associate to clinical professor of medicine; Albert J. Levine, from instructor to clinical assistant professor of medicine; Alfred L. Siegal, from clinical associate to clinical assistant professor of medicine; Earl N. Silber, from associate to clinical assistant professor of medicine and Jay J. Gold, from clinical instructor to clinical assistant professor of medicine.

**Personal.**—Dr. G. H. Pollock associate professor of psychiatry, and Jay E. McCormick, assistant clinical professor of psychiatry, both of the University of Illinois College of Medicine, have been named to the staff of the Institute for Psychoanalysis.—Dr. Tibor Benedek has been promoted to associate clinical professor of dermatology at Stritch School of Medicine of Loyola University.

**Society News.**—At a meeting of the Society of Medical History of Chicago, October 17, Dr. Francis J. Gerty, professor and head of the department of psychiatry, University of Illinois College of Medicine, spoke on "The Story of Three Women", and Dr. Joseph H. Kiefer, associate professor of urology at Illinois, "The History of Lithotomy."

**Special Lectures.**—Dr. Rachmiel Levine, chairman of the department of medicine, Michael Reese Hospital, and professorial lecturer, department of physiology, University of Chicago, delivered the Eighth Annual Phi Delta Epsilon Lectureship, October 29-31, on "The Endocrine Control of the Metabolism of Foodstuffs." Titles of the individual lectures were "Carbohydrate Metabolism"; "Protein and Fat Metabolism", and "The Nature of Hormonal Regulation."

Dr. Hans Ludvig Kottmeier, chief of the gynecological department, Radiumhemmet, and associate professor, Royal Karolinska Institute, Stockholm, Sweden, delivered the Solomon Theron De Lee Lecture at the Albert Merritt Billings Hospital, October 10. His subject was "Treatment of Uterine Carcinoma at the Radiumhemmet."

**Dr. Ray New Head of Orthopedics at Illinois.**—Dr. Robert D. Ray became professor and head of the department of orthopedics at the University of Illinois College of Medicine, September 1, filling the vacancy created by the death of Dr. Fremont A. Chandler in December 1954. Dr. Claude N. Lambert had been acting head. Dr. Ray, prior to coming to Chicago, was associate professor of surgery and head of the division of orthopedic surgery at the University of Washington College of Medicine, Seattle.

**Award to Edward Compere.**—The President's Academy Award of the American Academy of Physical Medicine and Rehabilitation was presented to Dr. Edward L. Compere recently. Dr. Compere, professor of orthopedic surgery at Northwestern University Medical School, received the honor in recognition of his outstanding work in restoring people to health and his leadership in developing the Liberty Mutual Rehabilitation Center of Chicago. Chicago physicians who were elected to office in the academy are Drs. Louis B. Newman, vice president, and Dorothea C. Augustin, assistant secretary-treasurer. The academy also gave its third place bronze medal to Drs. Arthur A. Rodriquez and Y. T. Oester, and John Fudema, R.P.T., and J. A. Fizzell, R.P.T., all of Chicago, for their scientific exhibit "Electromyography in Clinical Practice."

## HENRY

**Joint Meeting with Clergy and Physicians.**—Dr. Herman Chor, attending neuropsychiatrist at Wesley Memorial Hospital, Chicago, addressed the Henry County Medical Society, November 14, on "Psychiatric Correlation of Medical and Religious Approach to the Patient." All members of the Clergy of the County were guests of the society at this meeting.

## LAKE

**New Members.**—At the September 11 meeting of the Lake County Medical Society, the transfer of membership of Dr. Benjamin Rappaport from the Chicago Medical Society was approved. In addition, the following three physicians were accepted into membership: Drs. Charles A. Linke, 900 Old Trail, Highland Park; Walter L. Modaff, 225 Center Street, Grayslake, and Michael Cejtin, 1021 Glen Flora, Waukegan.

## MADISON

**Society News.**—"Rehabilitation of the Cardiac in Industry" was the subject of Dr. Lee B. Harrison, physician-in-chief at Missouri Pacific Hospital, St. Louis, before the Madison County Medical Society, October 4, at the Madison County Sanatorium, Edwardsville.

## MORGAN

**Physicians Entertain Lawyers and Wives.**—The Morgan County Medical Society entertained members of the Bar Association and their wives, October 2, at the Dunlap Hotel, Jacksonville. Following

a social hour and dinner, Mr. Alfred F. Newkirk, Springfield, discussed medical-legal problems.

## PEORIA

**Personal.**—The Medical and Surgical Clinic, 1002 North North Street, Peoria, has announced the association of Dr. Joseph S. Solovy, internist.

**"Mock Trial"—"The Doctor as a Medical Witness."**—The Peoria Medical Society held a meeting in conjunction with the Peoria Bar Association, October 16, on "The Doctor as a Medical Witness." Four representatives of the Law Department of the American Medical Association participated in a mock trial. Participants were C. Joseph Stetler, Director of the AMA Law Department; Ralph E. DeForest, M.D., Secretary of the Council on Medical Physics; Mr. Edwin J. Holman and Mr. William J. McAuliffe, Jr., both of the Law Department. In "mock trial" form, the lawyers and physicians acted out a case exactly as it would be done in court. In fact, they acted it twice—once to show "how not to do it" and once to show "how to do it".

In the "how-not-to-do-it" part of the "mock trial", it was easy to see how useless an "expert witness" can be if neither he nor the attorneys are prepared or know how to present their facts. The doctor, according to a news release, was not much help to the injured railroad man trying to collect damages for a permanent back injury.

"The defense attorney who was well-prepared and aggressive asked all the right questions—the ones the doctor couldn't answer. The doctor didn't have any records with him to refresh his memory, either, and when he did answer questions he sounded like an ancient medical textbook. The railroad man didn't recover a penny.

"The plaintiff was luckier in the second run-through of the trial, which was adapted from actual court records. This time, according to the release, the physician knew his case down to the last nerve, muscle and bone. Furthermore, he had his detailed records to back him up, and he explained them in simple words. He even brought along a shadow box to show illuminated x-ray films, and charts to show what and where the injury was. Speaking clearly and without the squirming manner of the "how-not-to-do-it" witness, he could have convinced anyone that his facts and conclusions were indisputable.

"The point of the whole show was to teach doctors and lawyers how to present their cases thoroughly and accurately, so that a just decision can be made in cases requiring expert medical testimony.

"Pointing out the need for educating doctors and lawyers in courtroom technique, Mr. Stetler said that between 50 and 60 per cent of all court cases involve a personal injury and require physicians as witnesses. In addition, many other kinds of cases have aspects which make it imperative for a judge or jury to have authentic medical testimony; for instance, contests of wills, life insurance suits in which the manner of death makes a difference in the amount of payment; and criminal cases from simple assault to murder."

The medical witness, Stetler explained, should not be on anyone's "side". Although he may be called by the plaintiff of the defendant, he should testify only to his medical findings and should not "color" his testimony in an effort to prove the case for one side.

## ST. CLAIR

**Society News.**—The St. Clair County Medical Society was addressed in East St. Louis, October 4, by Dr. Stanley Hampton.

## SANGAMON

**Society News.**—Dr. Carl V. Moore, Busch professor of medicine and head of the department of internal medicine, Washington University School of Medicine, St. Louis, addressed the Sangamon County Medical Society, October 4, at the Elks Club, Springfield, on "Newer Knowledge of the Purpuras."

## VERMILION

**Society News.**—Dr. William S. Dye, instructor in surgery, University of Illinois College of Medicine, Chicago, addressed the Vermilion County Medical Society in Danville at the Hotel Wolford, October 2, on "Medical and Surgical Aspects of Peripheral Vascular Disease."

## GENERAL

**Merit Increases for Welfare Employees.**—On October 4 Governor William G. Stratton announced the fifth merit increase in his administration, affecting approximately 7,000 employees of the Illinois Department of Public Welfare. The five merit increases have totaled $4,109,000 and have been provided within the operating appropriations of the department. No special appropriations were received to accomplish this purpose, according to a news release.

**Society News.**—Chicago participants on the program of the Gerontological Society in Chicago, November 8-10, included Drs. John R. Wolff and Howard Ganzer of the Cancer Prevention Center on "The Detection of Uterine Cancer in Women After Sixty."

**Ed Uzemack Chosen "Man of the Week."**—"Meet Mr. BIG" is the title of a column in *The News* of Niles Township by-lined by Sheryl Leonard, and featuring someone who has acquired an outstanding reputation in the community. The issue of September 20 announced the selection of Edward A. Uzemack, Skokie, Assistant Secretary and Director of Public Relations of the Illinois State Medical Association, as "Man of the Week." Mr. Big is representative of *B*usiness, *I*ndustry and *G*overnment. The *News'* story reviews the scholastic and occupational background of Uzemack, his membership in the Upper Lincoln PTA, in which he also

serves as co-chairman of publicity. It points out that he is director of the East Side Property Owners' Association, active in boy scout work, a member of the Chicago Press Veterans Association, the National Press Club and Sigma Delta Chi Fraternity, and of the Medical Society Executives' Conference.

According to the *News*, "the three years Uzemack spent in the Army were ones he shall never forget. He saw action in Germany during the Battle of the Bulge. For three and a half months he was a prisoner of War. These horrible months were spent in Stalag 9B—once a concentration camp.

"In order to keep occupied, he and two other newspaper men, also prisoners, got together to put out a daily newspaper. Fellow prisoners gave up their small supply of paper, and they put out a one sheet newspaper. This hand printed news sheet was sent from barracks to barracks. The news was obtained from one of the guards who detested the Nazi regime—and would pass information on to them, and from some of the French prisoners who had built a radio which they concealed in a cigar box. This tiny radio was taken apart and reassembled every day, in order to escape detection.

"News items from BBC were slipped to Ed on pieces of cigarette paper. All kinds of devious means were used to put out this one page news to the prisoners.

"The three newspaper men also organized a recreational and educational program. Each day Uzemack would give daily news analysis. In this manner, the men tried to keep their minds alert and away from the deprivation and hardships they suffered.

"To hear Ed", the News story says, " a great towering man, speak of his fondest hobby, is almost a paradox unto itself. He enjoys baking pies. Not ready mixed ones, but fresh ones. His children think him the greatest!

"It is easy to see, after spending a few moments with Ed Uzemack, that with his warmth and friendly personality, why Ed Uzemack is one of the top public relations men in the country."

Ed. Note—Congratulations, Ed.

**Rehabilitation Institute Plans Expansion.**—Plans are under way to launch a $1,500,000 remodeling program at the Rehabilitation Institute of Chicago, 401 East Ohio Street. When the renovation is completed sometime in June 1957, the third floor of the four story structure will contain facilities for forty-seven beds for in-patient training. Under the present set-up, services are available to out-patients only.

The institute, which has been operating since 1951, is not limited to any geographic boundary, but accepts patients on a medical referral only. While the greatest number of patients are amputees and cardiacs, all types of physically handicapped patients are served with three exceptions: blind, deaf and severe mentally ill.

Support for the institute comes from the Veterans' Administration, Northwestern University Medical School and the institute itself, whose funds stem from business and industry. Part of the remodeling cost will be defrayed with funds made available under the Hill-Burton Act.

The institute now houses facilities for occupational and physical therapy, psychological testing and job placement services, and administrative offices. One of the features of the remodeling program will be the conversion of the basement into research laboratories to determine and evaluate new types of prostheses.

Since its opening, the institute has cared for 900 patients, enabling most of them to be self-sustaining. The work classification unit is a cooperative project of the institute and the Chicago Heart Association. Thus far, the Placement Service has found it more difficult to find jobs for cardiac patients than amputees.

On October 9-10, specially conducted tours of the institute were a part of National Employ the Physically Handicapped Week.

The experience was a heart-warming one for this reporter. The aids to help restore these patients to a comparatively normal life are extensive and planned to anticipate every need—from devices designed for the wheel chair patient to those for a patient having the use of one hand only or no hands. The entire program aims for restoration for employment and restoration for self-management.

Dr. Joseph Chivers is medical director of the institute. Drs. Ben L. Boynton and Angelo P. Creticos are chiefs of physical and clinical medicine, respectively. Orthopedic consultants are Drs. Clinton L. Compere, Bradley W. Carr and Coleman J. O'Neill.

**1956 Care Food Crusade.**—From national agricultural stockpiles, the U. S. Government has allocated to CARE, without charge, life-giving supplies of milk powder, rice, flour, beans, cornmeal and cheese. CARE assembles these staples into twelve different package assortments to meet the varying food needs in nineteen countries of Europe, Asia, the Near East and Latin America. Each package will provide a month's supplementary food for four persons. A typical package contains twenty-two pounds of foods, including five pounds of milk powder, which makes twenty quarts; five pounds of rice; five pounds of flour, and seven pounds of cheese. Every one dollar contributed to CARE (Cooperative for American Remittances to Everywhere, Inc.) guarantees delivery of a Food Crusade package as a personal gift from the donor, whose own name and address to with each package subscribed. CARE Mission Chiefs, Americans stationed abroad, will supervise distributions to needy families and institutions in West Germany and Berlin, Greece, Italy, Yugoslavia, Hong Kong, Korea, Vietnam, India, Pakistan, Colombia, Costa Rica, El Salvador, Honduras, Panama, Israel and to Arab refugees in Lebanon, Jordan, Syria and the Gaza Strip.

Emphasis is placed on reaching refugee families. families of the unemployed, widows and orphaned

children, war invalids, the aged, victims of tuberculosis and other malnutrition diseases.

Donors may designate the countries they wish to help. Contributions in any amount for the Food Crusade should be sent to CARE, 189 West Madison Street, Chicago 2, Illinois, or to your local Railway Express Agency, which accepts CARE contributions as a public service.

**Fund for Sick and Disabled Physicians.**—Funds are presently available under the Dr. Adolph Gehrmann Fund for Sick and Disabled Physicians. Beneficiaries are any sick or disabled physician in need of financial assistance, or the widow of any physician for a period of not more than one year after the death of the husband. The fund cannot be used as an old age pension for physicians, but must rather adhere to the statement in the will to help "in his or their attempt to regain health." Applications for assistance or inquiries for additional information should be made to The Chicago Community Trust, 10 South La Salle Street, Chicago 3, Illinois. Telephone number is Franklin 2-3356.

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**Harry M. Hedge,** Evanston, formerly assistant professor of dermatology, Northwestern University Medical School, and Past President of the Illinois State Medical Society, Woman's Auxiliary to the Aux Plaines Branch of the Chicago Medical Society, October 26, on Care of the Skin from the Cosmetic Viewpoint.

**Leonard F. Jourdonais,** Evanston, associate professor of medicine, Northwestern University Medical School, Park Ridge Tops #1, November 13, at the Oakton School in Park Ridge, on Dangers of Obesity.

**Harry W. Southwick,** clinical assistant professor of surgery, University of Illinois College of Medicine, Hurley School Parent-Teacher Association, November 13, on Recent Advances in the Treatment of Cancer.

**William J. Corcoran,** attending pediatrician at Mercy Hospital, Nathan Hale School Parent-Teacher Association, November 15, on Results and Present Status of the Poliomyelitis Vaccine.

**George V. Byfield,** clinical assistant professor of medicine, University of Illinois College of Medicine, Junior Women's Auxiliary of Elmhurst College, November 27, on Advances in Medicine.

**Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:**

**Donald I. Bell, Evanston,** instructor in medicine Northwestern University Medical School, Englewood Branch to the Chicago Medical Society, October 9, on Six Hour Regimen for Surgery or Acutely Complicated Diabetes.

**Benjamin Pearlman,** clinical assistant professor of medicine, University of Illinois College of Medicine, Bureau County Medical Society in Spring Valley, October 9, on Use of Diuretics in Heart Failure.

**John L. Bell,** associate in surgery, Northwestern University Medical School, Whiteside-Lee County Medical Societies in Rock Falls, October 18, on Treatment of Burns.

**Charles D. Krause,** clinical assistant professor of obstetrics and gynecology, University of Illinois College of Medicine, Bureau County Medical Society in Princeton, November 13, on Toxemias of Pregnancy.

**James S. Schoenberger,** clinical assistant professor of medicine, University of Illinois College of Medicine, Englewood Branch to the Chicago Medical Society, November 13, on Management of Acute Renal Failure.

**Mitchell A. Spellberg,** associate professor of medicine, University of Illinois College of Medicine, Stock Yards Branch of the Chicago Medical Society, November 16, on Management of Ulcerative Colitis and Sequelae.

**Robert A. DeBord,** Peoria, member of the staff of St. Francis Hospital, Effingham County Medical Society in Effingham, December 10, on Thoracic Surgery in Infants and Children.

**Peter J. Talso,** associate professor and assistant chairman of the department of medicine, Stritch School of Medicine of Loyola University, Kankakee County Medical Society in Kankakee, December 18, on Collagen Diseases.

**Howard L. Penning,** Springfield, Montgomery and Macoupin County Medical Societies in Litchfield, December 19, on Office Gynecology.

**Winston H. Tucker,** Director, Evanston Health Department, Stock Yards Branch of the Chicago Medical Society meeting jointly with the Engelwood Branch, December 21, on Recent Advances in Poliomyelitis.

**Postgraduate Conference.**—On October 11, a Postgraduate Conference was held at the Pekin Country Club, Pekin, under the auspices of the **Postgraduate Education Committee** of the **Illinois State Medical Society** in cooperation with the faculty of the **Cook County Graduate School of Medicine of Cook County Hospital,** and with the **Tazewell County Medical Society** acting as host.

Speakers at the afternoon session were **Drs. Donald D. Kozoll,** associate professor of surgery, on "Gastrointestinal Bleeding"; **Anthony J. Nicosia,** associate professor of surgery, on "The Acute Abdomen"; **Armand J. Littman,** associate professor of medicine, on "Geriatric Problems in General Practice". Discussants will include **Drs. Robert G. Rhoades, Rudolph A. Helden,** and **James I. Weimer. Dr. Jacob E. Reisch,** Springfield, Councilor for the Fifth District, presided.

**Dr. Adam Slaw,** Delavan, president of the Tazewell County Medical Society, presided at the dinner. Speakers were **Dr. Reisch,** on "Current Medical Problems", and **Mr. Walter L. Oblinger,** Springfield, Associate Counsel of the Illinois State Medical Society, "Preview of the 1957 Legislature."

In the afternoon, wives of physicians were entertained by the Woman's Auxiliary to the Tazewell County Medical Society.

## DEATHS

**William A. N. Dorland***, retired, Tampa, Florida, formerly of Chicago, who graduated at the University of Pennsylvania School of Medicine in 1886, died September 11, aged 92. He was the author of the "American Illustrated Medical Dictionary," first published in 1900 and now in its twenty-second edition.

**Edward A. Elfeld**, retired, Arlington Heights, who graduated at the Homeopathic Medical College of Missouri, St. Louis, in 1891, died in Denver, October 5, aged 88.

**Richard G. Fort***, Glenview, who graduated at the University of Illinois College of Medicine in 1939, died October 2, aged 41. He was a member of the staff of St. Francis Hospital, Evanston.

**Adolphus N. Gordon, Sr.**, Chicago, who graduated at Meharry Medical College, Nashville, in 1894, died September 22, aged 86.

**Frederick Charles Jacobsen**, Palos Heights, who graduated at Jenner Medical College in 1907, died March 5, aged 80, of uremia due to carcinoma.

**David P. Johnson**, retired, Chicago, who graduated at Rush Medical College in 1902, died September 30, aged 91.

**Clement Stanislaw Marczak**, Lockport, who graduated at the Chicago Medical School in 1930, died in Chicago May 29, aged 67.

**Benjamin Markowitz***, Bloomington, who graduated at Stritch School of Medicine of Loyola University in 1922, died September 17, aged 60. He was a former president of the Illinois Society of Pathologists.

**Robert C. Menzies**, Chicago, who graduated at Rush Medical College in 1905, died September 23, aged 77. He had practiced medicine on Chicago's north side for more than 40 years.

**Herman Christian Newton***, retired, Chicago, who graduated at Northwestern University Medical School in 1905, died July 1, aged 80, of a heart attack.

**Georgia Wetmore Steffens**, retired, Evanston, who graduated at the Hahnemann Medical College and Hospital in 1918, died September 10, aged 73.

**Otto Wallis*, Chicago**, who graduated at Medizinische Fakultat der Universitat, Wien, Austria, in 1926, died September 9, aged 55. He was a member of the staff of Columbus and Frank Cuneo Memorial Hospitals.

**Milton A. Wiese***, Libertyville, who graduated at the University of Illinois College of Medicine in 1914, died September 18, aged 64. He was a member of the staff of Alexian Brothers Hospital, Condell Memorial Hospital in Libertyville, and St. Therese Hospital, Waukegan.

*Indicates member of the Illinois State Medical Society.

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## Oral K

A vitamin $K_1$ tablet for oral administration has become available. This drug, in doses of 2.5 mg. to 20 mg., was administered to 75 patients in whom excessively elevated prothrombin time values were produced by prothrombinopenic anticoagulant therapy. In 85 per cent of the patients studied, prothrombin time returned to a safe range (35 seconds or less, within 12 hours after the oral administration of vitamin $K_1$ in this dosage and in 98 per cent of the patients within 24 hours. The prothrombin time fell below the lower therapeutic level of adequate anticoagulation in 15 per cent of the patients at 12 hours following vitamin $K_1$. Under such circumstances the administration of heparin insured a continuing antithrombic effect until subsequent doses of coumarin or indandione agent again achieved an adequate hypoprothrombinemia. Since most hemorrhages during anticoagulation occur in association with prothrombin time values above 35 seconds, vitamin $K_1$ tablets for oral use provide an additional safeguard in coumarin and indandione therapy. *Stuart W. Cosgriff, M.D. The Effectiveness of an Oral Vitamin $K_1$ in Controlling Excessive Hypoprothrombinemia during Anticoagulant Therapy. Ann. Int. Med. July* 1956.

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# BOOK REVIEWS



PEPTIC ULCER, DIAGNOSIS AND TREATMENT. By Clifford J. Barborka, M. D., M. S., F. A. C. P., Associate Professor of Medicine & Chief, Gastrointestinal Clinics, Northwestern University Medical School; Attending Physician; Passavant Memorial Hospital; Senior Consultant in Gastroenterology, Veterans' Administration, Research Hospital, Chicago, Illinois; former Consulting Physician Mayo Clinic. And E. Clinton Texter, Jr., M.D., Associate in Medicine and Assistant Chief Gastrointestinal Clinic, Northwestern University Medical School; Attending Physician, Passavant Memorial Hospital; Attending in Gastroenterology, Veterans' Administration Research Hospital, Chicago, Illinois. Little, Brown & Co. — Boston-Toronto. . 290 pages — $7.00.

This little book is peculiar or at least not ordinary. It considers the various subjects connected with peptic ulcer in a most direct manner. Numerous theories are not included. This man's and that man's opinion are not related. The authors proceed to set down their opinion of the "present day thought" in plain words. Their presentation is made after summing up the attitude of clinicians and using their own wide experiences to make a practical conclusion. And yet this concise method of dealing with each item is not dogmatic. Their presentation is quite humbly accomplished.

The work is quite timely for the advancement in treatment has been very rapid in the last half dozen years. It is interestingly written and thus the reader not only receives benefit in finding the exact answer to the question in mind, but also unintentionally reads on because of the "nice" use of English. The volume is well indexed. It is quite comprehensive. It serves a definite purpose for the physician, student or practitioner.

C. P. B.

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CHRISTOPHER'S TEXTBOOK OF SURGERY. Sixth edition. Loyal Davis, M. D., Editor, 1484 pages; 1359 illustrations on 716 figures. Published by W. B. Saunders Company, Philadelphia, London. 1956. $15.50.

The first edition of this fine textbook of surgery was published 20 years ago, and it has undergone a number of editions. The current volume is edited by Loyal Davis, assisted by a large corps of experienced teachers from all parts of the country. The book has always been very popular among medical students as well as surgeons everywhere.

It was not primarily intended to cover the entire field of surgery from a technical standpoint, but to instill in the readers a desire to learn more about the many surgical conditions and the various techniques used for their relief.

(*Continued on page* 82)

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## BOOK REVIEWS (Continued)

Each contributor has been carefully selected and they write in their own style of teaching in the effort to give the student a better knowledge of these individual methods, rather than to note the similarity of the presentation of the many subjects discussed in the book if all were written by one surgeon.

The many illustrations and figures appearing in this new edition add materially to the interest of the reader and increase his knowledge of the many conditions that are presented.

It seems quite appropriate that the publishers of this book selected Doctor Davis to edit the sixth edition, as he had been so closely associated with Dr. Frederick Christopher for many years.

It is the firm belief of the reviewer that the Sixth Edition of Christopher's Textbook of Surgery will be as well received by students and surgeons as were the previous editions during the past 20 years.

## BOOKS RECEIVED

EPILEPSY AND THE LAWS A Proposal for Legal Reform in the Light of Medical Progress. By Roscoe L. Barrow, Dean, University of Cincinnati College of Law, and Howard D. Fabing, M. D., Past-President, American Academy of Neurology. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 49 East 33rd Street, New York 16, New York. $5.50.

OCCUPATIONAL HEALTH NURSING. By Mary Louise Brown, R. N., M. A., Assistant Professor of Public Health, Yale University School of Medicine, in association with John Wister Meigs, M. D., Associate Professor of Public Health, Yale University School of Medicine. Springer Publishing Company, Inc., New York. $4.50.

INTERNAL SECRETIONS OF THE PANCREAS; Volume 9, Ciba Foundation Colloquia on Endocrinology. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O. B. E., M. A., M. B., B. Ch., and Cecilia M. O'Connor, B. Sc. 100 illustrations. Little, Brown and Company, Boston. $7.00.

AGEING IN TRANSIENT TISSUES: Volume 2, Ciba Foundation Colloquia on Ageing. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O. B. E., M. A., M. B., B. Ch., and Elaine C. P. Millar, A. H. W. C., A. R. I. C. 96 illustrations. Little, Brown and Company, Boston. $6.75.





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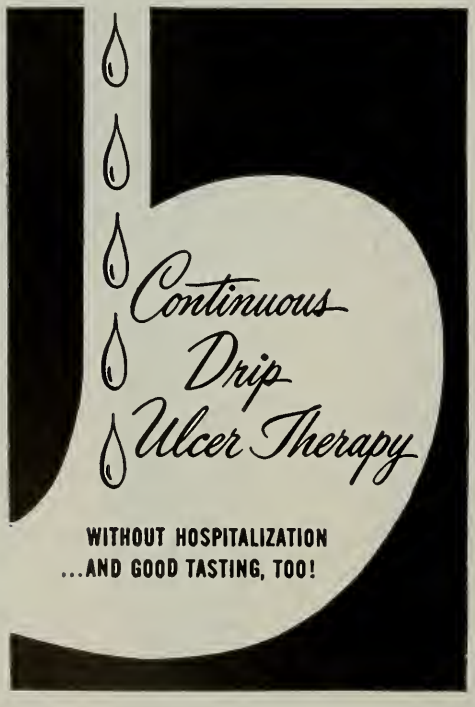
MD-J-356

*T.M.

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## Private practice in England

Without examining all the possible remedies for a state of affairs which is serious enough if his conclusion is soundly based, Dr. Hall considers that one step should be taken to counter "conditions which encroach on the freedom of medicine," and that is that the Association should "preserve and foster the practice of medicine outside the National Health Service. . . ." This proposal is in line with Association policy. "The greater the area of freedom provided by the private practice of medicine," Dr. Hall writes, "the greater will be the encouragement to maintain a general high standard and the stronger the deterrent to the introduction into the National Health Service of terms and conditions of service which we believe will make such standards unattainable." This proposition will be unpopular with those who see the all-powerful and paternal State as the provider of all good things. But it is one that will appeal to those who see the area of individual responsibility gradually being submerged in a collective mediocrity, in "a society harried, hag-ridden by regulations, and financially penalized"—these last words taken by Dr. Hall from an article in the TIMES LITERARY SUPPLEMENT. In addition to the reasons Dr. Hall gives for the desirability of encouraging private practice, there is one that is easily lost sight of in this age of levelling down. Some patients and some doctors are temperamentally averse to "service conditions." The great risk to the public of the N.H.S. is that it will lead to a standardized medicine practiced by a standardized doctor on what he may come to regard as a standardized patient. Of all professions, medicine needs diversity of opportunity and a wide margin of freedom to bring out to the full the doctor's sense of personal responsibility to the sick person. Dr. Hall's appeal for the encouragement of private practice must be looked at in this context, and will no doubt receive the practical support of the Association of which he is President.*Editorial. The Presidential Address. Brit. M. J. July* 14, 1956.


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A recent clinical study* of 46 ambulatory nonhospital patients treated with Nulacin† and followed up to 15 months describes the value of ambulatory continuous drip therapy by this method. Total relief of symptoms was afforded to 44 of 46 patients with duodenal ulcer, gastric ulcer and hypertrophic gastritis.

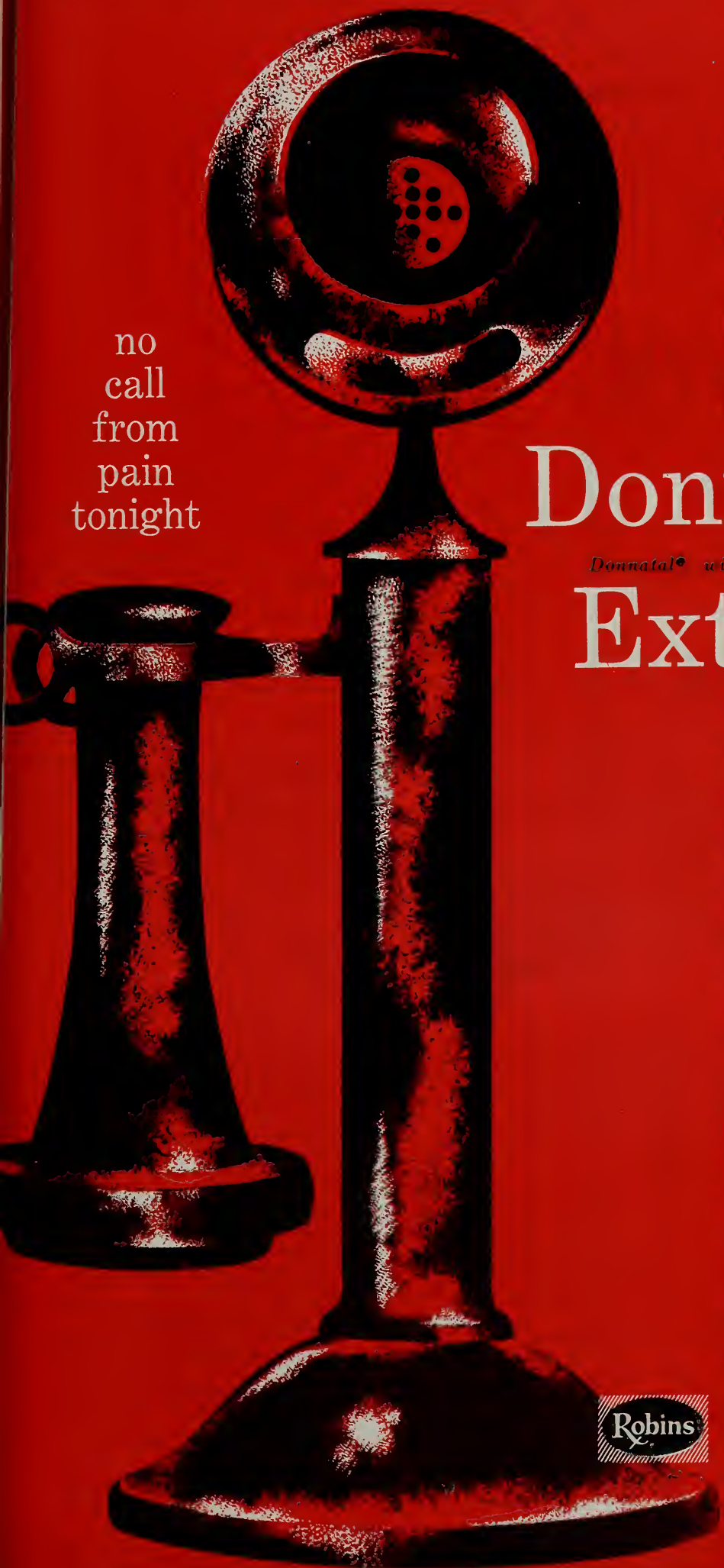
The delicately flavored tablets dissolve slowly in the mouth (not to be chewed or swallowed). They are not noticeable and do not interfere with speech.

Nulacin tablets are supplied in tubes of 25 at all pharmacies. Physicians are invited to send for reprints and clinical sample.

*Steigmann, F., and Goldberg, E.: Ambulatory Continuous Drip Method in the Treatment of Peptic Ulcer, Am. J. Digest. Dis. 22:67 (Mar.) 1955.

†Mg trisilicate 3.5 gr.; Ca carbonate 2.0 gr.; Mg oxide 2.0 gr.; Mg carbonate 0.5 gr.

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10 to 12 hours uninterrupted pain relief in a single tablet

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# Extentabs*

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| Hyoscine Hydrobromide | 0.0195 mg. |
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| Atropine Sulfate | 0.0582 mg. |
| Hyoscine Hydrobromide | 0.0195 mg. |
| Phenobarbital (¼ gr.) | 48.6 mg. |

1. [illegible] and Gilman, A.: The Pharmacologic Basis of Therapeutics, N. Y., The Macmillan Co., 1955, p. 122

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Each 2 cc. dose contains:

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| Niacinamide | 50 mg. |
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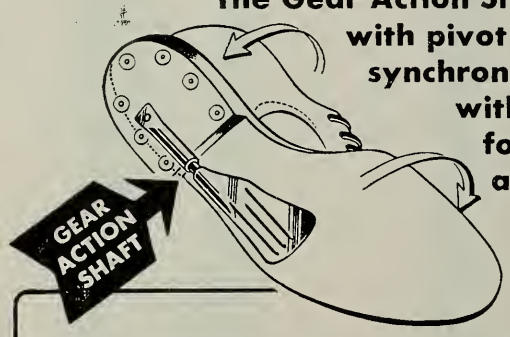
## Hemorrhoids

The management of hemorrhoids offers three alternatives: They may be neglected, injected, or resected. In my experience, hemorrhoids in over 20 per cent of patients were so nearly symptomless as to require no therapy. In a nonspecialist practice, this incidence must be considerably higher. *Robert Turell, M.D. Present Status and Modern Treatment of Hemorrhoids. New York J. Med. July* 15, 1956.

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Coccidioidomycosis, which was known up to a decade ago mainly to physicians and mycologists working in the endemic area, must now be seriously considered in the differential diagnosis of chronic pulmonary lesions in nonendemic areas. Because of the great numbers of military personnel who were stationed in endemic areas during and after World War II, a widespread scattering of the disease occurred, although the area itself apparently showed no signs of expanding. Denis J. O'Leary, M.D. and Francis J. Curry, M.D., Am. Rev. Tuberc., April, 1956.

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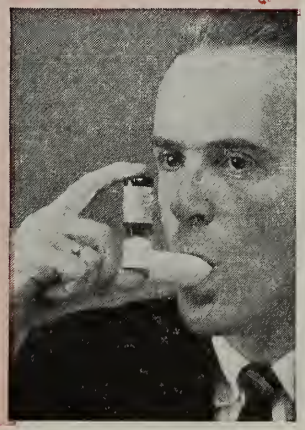
Dosage: One to two tablets q.i.d., before meals and on retiring.

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## Stomach cancer

The combined observations of many investigators have established certain fundamental facts which must be observed in planning an adequate operative procedure. The frequency with which the duodenum is involved up to 1.5 cm. beyond the pylorus and with which the proximal spread of the disease extends beyond the palpable and visible limits of the tumor up to 4 to 5 cm. makes obligatory the extension of the distal and proximal procedures of the resection beyond these limits. When this cannot be accomplished by anything short of gastrectomy, total removal of the stomach must perforce be done. The relation of the position of the tumor to the zones of common lymphatic spread must be given greater consideration in planning the operative procedure. As McNeer's studies have shown, for lesions in the pars media, there is a 45 per cent incidence of involved lymph nodes along the splenic vessels, which can be removed surgically only by concomitant resection of the spleen and the left half of the pancreas. Extension of the operation to include these structures as the routine procedure for lesions in this area must be seriously considered. Similarly, the high incidence of extension of the disease into

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the esophagus from primary lesions of the cardia precludes the approach to cancers in this area by the subdiaphragmatic route. Transthoracic or abdominothoracic exposure and wide removal of the lower segment of the esophagus must be done in all such cases. Falling operative mortality rates from an average of 18 to 20 per cent a few years ago to figures in the neighborhood of 5 to 7 per cent represent a gain of approximately 10 per cent of patients who have at least a chance for ultimate cure. While these lower mortality figures are by no means representative of the national average, that they are attainable has been demonstrated. *Thomas J. Anglem, M.D. The Outlook for Increased Salvage in Gastric Cancer. Rhode Island M.J. June* 1956.

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## The incidence of gallstones

Gallstones are associated with the majority of disorders of the biliary tract. It is estimated that 10 per cent of the adult population in the United States have gallstones. *Frank Glenn, M.D. Gall Bladder Disease. New York J. Med. July* 15, 1956.


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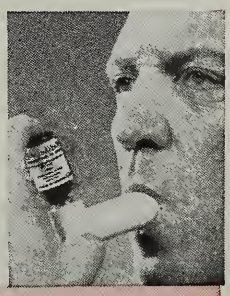
Riker brand of isoproterenol HCl 0.25% solution in inert, nontoxic aerosol vehicle. Each ejection delivers 0.06 mg. isoproterenol. In 10 cc. vial with metered-dose valve, sufficient for 200 inhalations.

Medihaler-Epi replaces injected epinephrine in emergency situations in which respirations have not ceased. It provides rapid relief in acute food, drug, or pollen reactions (including urticaria, bronchospasm, angioneurotic edema, edema of glottis, etc.). In most instances only one inhalation is necessary.

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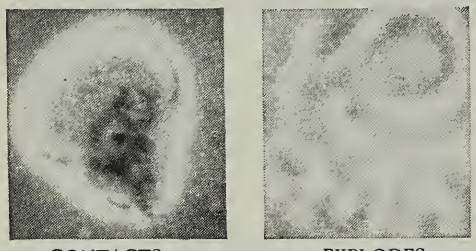
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*References:* 1. Davis, C. H.: J.A.M.A. *157*:126 (Jan. 8) 1955. 2. Davis, C. H.: West. J. Surg. *63*:53 (Feb.) 1955.

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‹ ›

The most unfortunate feature of tuberculosis in elderly persons is that it usually has no distinctive symptom. The cough, sputum, dyspnea, slight dyspepsia and a general feeling of lassitude are all put down to increasing years. It is only when sudden pain or hemoptysis occurs that the patient becomes alarmed and seeks advice. It is then that advanced, old-standing disease is found. and the damage done from the wide distribution of tubercle bacilli from this focus of infection over a number of years can be visualized. F. R. G. Heaf, M.D., J. Royal Inst. Pub. Health and Hygiene, Nov., 1955.

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Send original articles and membership correspondence to Harold M. Camp, Monmouth, Ill.

Send changes in the mailing list to Managing Editor, 185 N. Wabash Ave., Chicago 1, Ill.

Subscription price of this JOURNAL to persons not members of the Illinois State Medical Society is $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands and Mexico. $5.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Entered as Second-Class Matter November 12, 1952 at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate postage provided for in section 1102, Act of October 8, 1917, authorized July 15, 1918. Printed monthly by The Wayside Press, Mendota, Illinois. Office of Publication, 1501 W. Washington Road, Mendota, Illinois. POSTMASTER — Send change of address on form 3579 to 1501 W. Washington Road, Mendota, Illinois.



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# The Month in Washington



Washington, D. C. — Federal health and medical spending for all agencies of government this fiscal year is expected to reach a new high peak. The total is placed at $2,558,719,168, an increase of nearly 13% over the last fiscal year, which itself set a new record.

The spending is spread among 21 departments, agencies and commissions concerned in whole or part with health or medicine. They range from an impressive $825,024,300 for the Veterans Administration to a small sum of $12,145 for running the Office of the Attending Physician of Congress.

In between is a broad range of health and medical activities, including money for implementing the many health programs inaugurated by the 84th Congress. The totals are compiled each year by the American Medical Association's Washington Office. The report, the only consolidated Federal medical budget published, is based on actual appropriations by Congress and program data supplied by the federal agencies.

The medical budget total, divided into cost for each man, woman and child in the country, amounts to $15.17 a year, while each family in the U. S. will be paying $54.61 for this spending, based on Census Bureau figures for population, family size and employment.

Compared with last year's spending, the Defense Department has dropped to second place with its spending estimated at $790,105,000, thus giving way to the VA. The Defense Department shift from the top spending spot, despite a $41 million item for the new dependent's medical care program, is due primarily to more effective joint utilization of facilities, fewer personnel assigned to operation and a planned drop in hospital and dispensary construction.

Department of Health, Education, and Welfare spending for the year ending next July 1 amounts to $772,661,800, which puts that agency's total within striking distance of the two top spenders in the health-medical field. Compared with last year's $526,935,400, HEW spending this year is up a resounding 46%, due in part to more Hill-Burton hospital construction money, record research funds, and permanent and total disability payments.

Following is a table of spending by the 21 agencies this year and last:

| AGENCY | FISCAL 1957 | FISCAL 1956 |
|---|---|---|
| Veterans Administration .. | $825,024,300 | $790,185,800 |
| Department of Defense .. | 790,105,000 | 818,104,500 |
| Department of Health, .... Education and Welfare .. | 772,661,800 | 526,935,400 |
| Federal Civil Defense .... Admin. ..... | 49,810,000 | 30,450,000 |
| Atomic Energy Commission | 31,525,000 | 27,700,000 |
| International Cooperation .. Admin. ..... | 29,310,000 | 25,441,000 |
| Department of State ..... | 15,496,000 | 13,669,790 |
| Federal Employees Health Program ..... | 10,000,000 | 6,000,000 |
| National Science Foundation | 8,000,000 | 5,000,000 |
| Department of Labor ..... | 7,151,126 | 7,336,000 |
| Department of Interior .... | 6,138,205 | 5,770,000 |
| Panama Canal Zone ..... | 6,055,300 | 5,702,900 |
| Department of Treasury .. | 3,511,700 | 2,990,000 |
| Department of Justice .... | 1,580,000 | 1,470,000 |
| Federal Trade Commission | 1,000,000 | 1,000,000 |
| Department of Commerce .. | 547,914 | 277,586 |
| Civil Service Commission .. | 386,000 | 382,600 |
| National Advisory Committee to Selective Service .. | 180,000 | 180,000 |
| President's Comm. for .... Handicapped ..... | 134,678 | 130,000 |

(*Continued on page 30*)

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a stiff neck
for three weeks
just from
a little sneeze?"



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**WASHINGTON (Continued)**

| | | |
|---|---|---|
| Health Resources Advisory Comm. | 90,000 | 101,000 |
| Office of Attending Physician of Congress | 12,145 | ——— |
| TOTALS | $2,558,719,168 | $2,268,826,576 |

NOTES

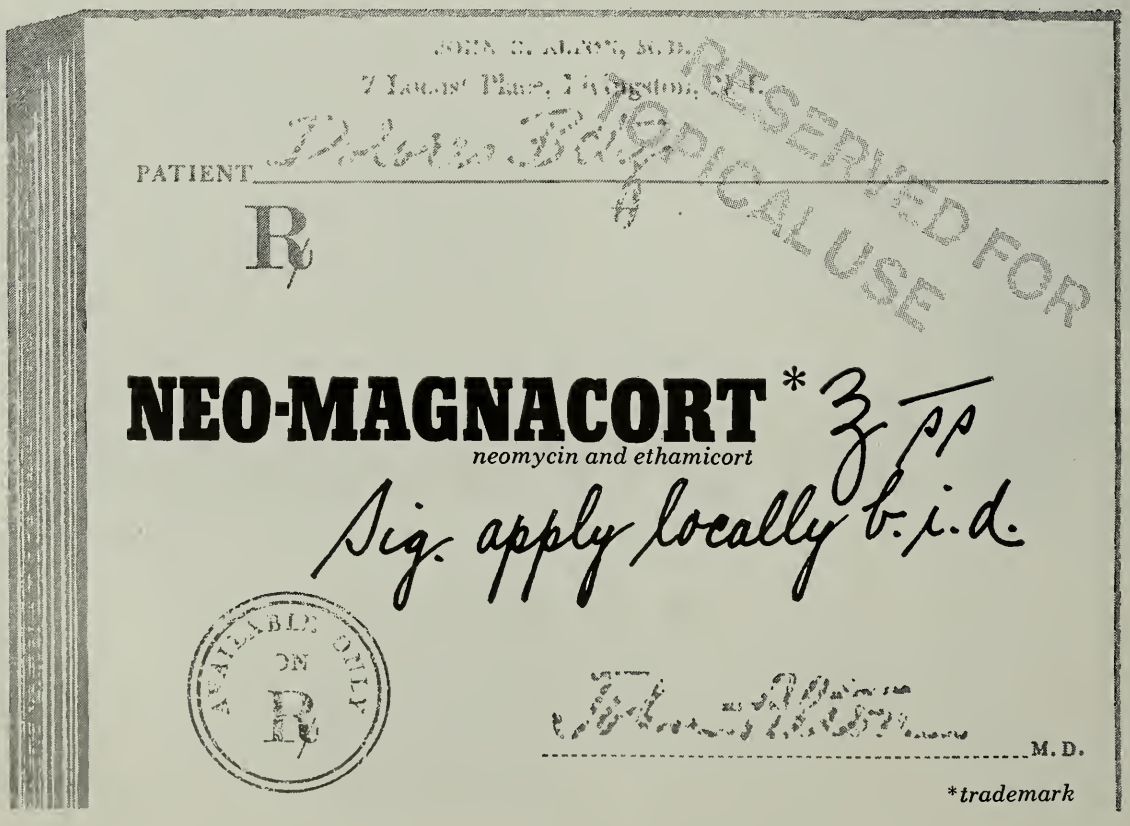
Dr. Leroy E. Burney, PHS surgeon general since last August, has announced a number of shifts in major posts within the service. They include Dr. John Cronin, chief of the Hill-Burton program, to head the important Bureau of Medical Services; Dr. Jack Masur, from this bureau to directorship of the Clinical Center at Bethesda, Md.; Dr. G. Halsey Hunt, associate chief of the bureau, to a new Center for Research on Aging at National Institutes of Health; Dr. Donald W. Patrick from the Clinical Center to PHS hospital at San Francisco; Dr. Vane M. Hoge, from associate chief of the bureau to Hill-Burton.

With the death of Rep. Percy Priest of Tennessee and the election of a Democratic House, Rep. Oren Harris, Democrat, of Arizona, assumes chairmanship of the important House Interstate and Foreign Commerce Committee. It handles most health legislation in the House. The companion Senate Committee on Labor and Welfare again will be headed by Senator Lister Hill (D., Ala.).

‹ ›

## Liability for hospital bills

Probably the most unsettled problem in this field is the liability of a relative to pay a hospital bill which he did not directly incur. At common law, the father was liable for the bill of his wife. In practically every jurisdiction, the duty of support has been extended by statute. The better and more prevalent view seems to be that the hospital is entitled to restitution from anyone under a duty to support the indigent patient. This right is not based on statutory provisions giving a specific course of action but is based on the common law principle of restitution to the effect that one who unofficially performs the duty of another is entitled to recovery. *Israel Packel. The Hospital and the Patient. J. Albert Einstein Med. Cen. June* 1956.

The
ILLINOIS
Medical Journal

Official Journal of The Illinois State Medical Society

DECEMBER, 1956
VOL. 110. NO. 6

# Urinary Incontinence in the Female

JOHN C. ULLERY, MD., COLUMBUS, OHIO

URINARY incontinence in the female may be defined as the inability to control the outflow of urine. It may vary in degree from an occasional slight involuntary escape of a few drops to the complete and continuous uncontrolled flow of the entire output. This type of disability may be classified as complete or partial. Complete incontinence signifies that the urine is more or less constantly lost whereas partial incontinence is the intermittent or occasional involuntary loss from the urinary system. Because of the variety of causes of this condition in the female and the challenge which the difficulties of its correction often present, it has been a subject which has engaged the attention of gynecologists and urologists for many years.

The causes of incontinence in the female may be listed as follows:

I COMPLETE INCONTINENCE
1. Congenital anomalies
2. Nervous system diseases
3. Destruction of the urethra
4. Fistulae

II PARTIAL INCONTINENCE
1. Congenital anomalies
2. Postoperative overdistension
3. Intrinsic lesions of bladder neck
4. Extrinsic lesions
5. "False incontinence"
6. Nervous system diseases
7. Enuresis
8. Stress incontinence

It may be seen from the outline that several etiological factors are listed both under complete and partial incontinence. Such examples are congenital anomalies and nervous system diseases. Both of these may cause either a total or continuous loss of urine or an occasional slight involuntary escape of a few drops, the amount depending upon either the type of anomaly or nervous system disease present and the extent of the condition.

I COMPLETE INCONTINENCE
1. Congenital Anomalies
   a. Hypospadias
   b. Epispadias
   c. Exstrophy of bladder
   d. Ectopic ureter
   e. Absence of urethra
   f. Faulty development of sphincters

The congenital defects of hypospadias and epispadias are extremely rare. These two conditions closely simulate defects resulting from trauma or disease. The treatment is reconstruction of the urethra with a surgical plastic pro-

*From the Department of Obstetrics and Gynecology, College of Medicine, Ohio State University, Columbus, Ohio.

*Presented before the General Assembly, 116th Annual Meeting, Illinois State Medical Society, Chicago, May 15-18, 1956.*

cedure. The percentage of cures is not high as too frequently the operation, although resulting in a reconstruction in a semblance of the urethral tube, does not produce improvement in urinary control. Exstrophy of the blader is the most easily and readily recognized malformation of the bladder. In this condition the anterior wall of the bladder is usually absent, leaving the posterior wall with its trigone and ureteral orifices exposed on the anterior wall of the abdomen. The treatment has been varied. Plastic procedures have met with little or no success and the operative procedure of choice today is to first perform a uretero-intestinal anastamosis to establish urinary continence and then in a later procedure to excise the extrophied bladder. It is recommended that the operation be performed during the first year of life if possible as infants tolerate the operation well and are given a better chance for normal development if done early.

Ectopic ureter is a malformation in which one or both ureteral orifices are misplaced from their normal opening into the bladder in the upper part of the trigone, to locations within the urethra, in the vestibule, or within the vagina or uterus. Urinary incontinence is nearly always a symptom leading to the discovery of this anomaly. The incontinence which is present in the female in this condition is of a peculiar type in that there is a constant leakage of urine but at the same time normal periodic voiding. It must be differentiated from uretero-vaginal fistula and small vesico-vaginal fistulae. The age and the history of the patient are important and will lead to an earlier diagnosis than in the past. Treatment consists of some type of implantation of the ureter into the bladder or ligation of the ureter either abdominally or vaginally. The abdominal routine is preferred. Sometimes it is also necessary to do a nephrectomy or heminephrectomy. Transplantation of the ureter into the bladder would seem to be the most logical approach provided there is no infection, and the dissection of the ureter in its lower course can be safely performed.

Absence of the urethra as a congenital anomaly also is of a rare occurrence but has been reported at birth. The treatment of complete absence of the urethra is dependent upon its cause. Congenitally absent urethra lends itself to certain types of surgical reconstruction and if so, should be attempted. Faulty development of urethral sphincters may also occur as the cause of a congenital malformation. The diagnosis of such conditions requires complete urinary studies, including endoscopic examination and cystometric studies. It the diagnosis can be established, reconstruction of the internal urethral sphincter mechanism by a plastic procedure may result in a complete cure.

I COMPLETE INCONTINENCE
2. Nervous System Diseases
1. Congenital
a. Spinal bifida
2. Acquired
EFFERENT PATHS
a. Vascular accidents
b. Cord or brain tumors
c. Cord trauma
d. Multiple sclerosis
e. Transverse myelitis
f. Pott's disease of spine
AFFERENT PATHS
g. Tabes dorsalis
"Paradoxical Incontinence"

The nervous system diseases resulting in complete incontinence may be congenital or acquired. The most frequent congenital lesion that can occur is spina bifida. It often results in a complete incontinence of urine. Although frequently this condition occurs early in life, it may not become evident until adulthood. The presence of a spina bifida should always lead one to inquire particularly as to the patient's ability to control the passage of her urine. The lesion may occur in varying degrees, but when the lesion is in the sacral region, as it most frequently is, it may be of sufficient extent to cause disturbance of the anterior sacral routes. Urgency, frequency of urination and spastic irritable bladder with varying degrees of incontinence are the usual symptoms. Operative procedures offer the best results in treatment. It is usually done by the formation of a sphincter by some type of fascial or muscle transplant. The acquired lesions of the nervous system diseases causing complete incontinence result in general types, those affecting the efferent motor pathways to the bladder and those which affect the sensory or afferent pathways resulting in loss of bladder sensation. Lesions affecting the efferent pathways are: cerebral vascular accidents, tu-

mors of the brain or spinal cord, traumatic injury to the spinal cord, multiple sclerosis, transverse myelitis, and Pott's disease of the spine. Treatment of these diseases depends upon the etiologic factor. If the cause of the agent or factor is removed, the incontinence may be on a temporary basis only. However, if the disease is progressive, but the prognosis is sufficiently good, operations in the form of a plastic procedure or fascial transplant could be attempted.

Tabes dorsalis, or "paradoxical incontinence" is a most common disturbance of the sensory afferent pathways to the bladder. The primary symptom in this condition of incontinence is a loss of bladder sensation including the desire to void. The bladder becomes overdistended with a consequent loss of muscular tone. Eventually the sphincter mechanism gives away and dribbling from the over-filled bladder occurs. Infection is a frequent occurrence. Ascending pyelonephritis is a serious complication. The treatment consists of advising the patient to void at least every two hours. Certain drugs which increase bladder tone may also be given. Acetylbetamethylcholine (Mecholyl)® bromide in doses of 0.2 gm. orally three times daily may help to increase the bladder tone. Catheterization may be frequently necessary or the retention of an indwelling catheter may be of help in increasing the muscular tone of the bladder. Infection should be treated by the use of antibiotic therapy, the type to be determined by the causative organism.

I COMPLETE INCONTINENCE
- 3. Destruction of the Urethra
  - a. Trauma
    - 1. Obstetric
    - 2. Injury
  - b. Carcinoma
  - c. Irradiation
  - d. Ulcerations
    - 1. Lymphopathy venereum

Destruction of the urethra may result from trauma, carcinoma, irradiation, or ulcerations. The obstetrical causes may be a sloughing of the urethra as a result of prolonged compression between the head of the child and the symphysis pubis, pressure of a breech presentation in prolonged labor, or careless forceps manipulation. Fortunately, due to the improved obstetric care, these conditions are growing less in frequency. The treatment consists of a plastic operation with reconstruction of the urethra. Carcinoma may result in complete incontinence with destruction of the urethra by its occurence in the urethra itself, or it may result from a radical resection of carcinoma. The treatment may consist of formation of a new urethra by plastic construction from the vulva or diversion of the urine with uretero-intestinal anastamosis. Ulcerative lesions, particularly lymphopathy venereum, may finally result in complete destruction of the urethra. Treatment would consist of the use of procedures as in carcinoma or irradiation destruction of the urethra.

I COMPLETE INCONTINENCE
- 4. Fistulae
  - a. Vesico-vaginal
  - b. Vesico-urethral
  - c. Vesico-urethral-vaginal
  - d. Vesico-uterine
  - e. Uretero-vaginal
  - f. Uretero-cervical
  - g. Vesico-intestinal
  - h. Vesico-abdominal

  Etiology of Fistulae
  - 1. Obstetrical
  - 2. Carcinoma
  - 3. Irradiation
  - 4. Operative
    - a. Hysterectomy
      - 1. Total
      - 2. Vaginal
      - 3. Wertheim
- 5. Tuberculosis

Fistulae constitute a definite cause of incontinence. The fistulous tract usually connects the lower urinary and genital tracts. They may be vesico-vaginal, vesico-urethral, vesico-urethral-vaginal, vesico-uterine, uretero-vaginal, uretero-cervical, vesico-intestinal or vesico-abdominal. They may be the result of obstetrical injuries, usually being caused by necrosis produced by long labor, or actual laceration of the bladder wall by ill advised instrumentation. Cesarean section may produce uretro-vesical fistulae. The type of urinary fistula encountered in vaginal delivery is usually vesico-vaginal, or urethro-vaginal. Cervical carcinoma in its later stages, and irradiation therapy may also produce fistulae. In patients with pelvic malignancy, the onset may be at any time. Following irradiation

therapy a fistula may develop several months or on occasion a year or two after completion of the treatment. Fistulae may occur following pelvic surgery in either total, vaginal or radical Wertheim hysterectomy. With the increased operative procedures used for the treatment of pelvic malignancy the incidence of the development of fistulae has increased. Vesico-vaginal fistulae which occur as complications to pelvic surgery usually become apparent between the fifth and tenth postoperative day. Tuberculosis, although of a rarer occurrence, may also occasionally produce fistulae when the infection involves the bladder and urethra.

The diagnosis of fistulae is made by vaginal and cystoscopic examination. The treatment varies according to the type of fistula and the location present. Vesico-vaginal fiistulae seldom heal spontaneously. Most require a surgical procedure. This should not be undertaken until the urine has been completely cleared of all infection. Fistulae occuring from traumatic procedures or operations require great individualization and modification of technique according to the merits of each case. They may be approached by the vaginal or abdominal routes. Occasional spontaneous cures of uretero-vaginal fistulae may take place and sufficient time should be allowed for this to happen. Catheterization of both ureters is a useful procedure for this operation. The fistulae associated with malignancy do not lend themselves to correction, and those that occur following irradiation therapy for carcinoma of the uterus are difficult to cure because of the avascularity and sclerosis of the tissues about the fistula.

II PARTIAL INCONTINENCE

1. Congenital
   a. Diverticulum of urethra
   b. Valves of urethra
2. Post-operative overdistension
3. Intrinsic Lesions of bladder neck
   a. Tumors
   b. Calculi
4. Extrinsic Lesions
   a. Tumors of uterus
   b. Adnexal masses or neoplasms
   c. Prolapse of the uterus
   d. Recto-sigmoid carcinoma
   e. Diverticulitis
5. "False incontinence"
   a. Inflammatory
      1. Monilia
      2. Trichomonas
   b. Endocrine
      1. Diabetes mellitus
      2. Diabetes insipidus
6. Nervous system diseases
7. Enuresis
8. Stress Incontinence

URGENCY AND FREQUENCY

Partial incontinence of urine in the female may be the result of congenital lesions, post-operative overdistension, intrinsic lesions of the bladder neck, extrinsic lesions, the so-called "false incontinence," nervous system diseases, enuresis, or stress incontinence.

Most common of the congenital lesions causing partial incontinence are: Diverticulum and valves of the urethra. The cause or causes of diverticulum of the urethra are debatable. It is believed by some to be of congenital origin and others due to infection of the urethra itself, possibly from an infection of the urethral glands. In any event, in addition to urgency and frequency, partial incontinence may also occur. The diverticulum may vary in size from a few millimeters in diameter to several centimeters. The diagnosis is made upon cystoscopic and endoscopic examination, along with anterior or lateral cysto-urethrogram studies. The treatment is dissection and excision of the diverticulum and reconstruction of the urethra. Congenital valves of the urethra may be diagnosed by endoscopic examination. Treatment may be fulguration or excision of the valves by a plastic procedure.

Post-operative overdistension of the urinary bladder may result in incontinence and is a direct result of lack of attention to post-operative care. Careful preventive measures should always be used with every post-operative patient in order to avoid the occurrence of this condition. A rigid bladder evacuation regime should be established on all post-operative patients. Incontinence is usually accompanied by severe pain, and in many cases is interpreted to be the result of surgery rather than from overdistension of the urinary bladder.

Once the overdistension has been recognized, the treatment is immediate catheterization. Ex-

plicit measures should be taken to see that the occurrence is not repeated. Catheterization at least every eight hours post-operative is indicated, and more frequently, if the patient complains of urinary discomfort.

Intrinsic lesions of the bladder neck may interfere with normal sphincter mechanism. They are mainly, tumors and calculi; their action is usually mechanical, or to initiate an inflammatory reaction in the bladder or urethra. Their treatment is removal of the underlying cause.

Extrinsic lesions producing partial incontinence in the female can be caused by other organs which adjoin the bladder; they are mainly tumors of the cervix or corporis uteri, inflammatory or neoplastic adnexal masses, prolapse of the uterus, recto-sigmoid carcinoma, or diverticulitis. Their effect may be due either to pressure on the bladder, or direct extension to the bladder wall of an inflammatory or malignant process. The treatment depends upon the removal of the etiological factor.

"False incontinence" should also be considered in all cases of partial incontinence in the female. Actually it is not incontinence, but an extreme form of urgency and frequency of micturition. It may vary from mild to severe. Infection, particularly in the posterior bladder and urethra neck is a frequent cause of this condition. It may occur at any stage of life and is generally an ascending infection due to monilia, trichomonas, or other types of bacteria. There is almost always an associated inflammatory disease of the cervix, vagina or adnexae. In this group, the most pronounced symptom is an extreme urgency or frequency with polyuria simulating incontinence. The causative factor may also be endocrine, such as diabetes mellitus or diabetes insipidus. Diagnosis may be made on careful pelvic examination, urinalysis, and bacteriological studies and smears from the cervix, vagina and urethra. Treatment is removal of the cause, or control of the diabetes.

Nervous system diseases as mentioned above may also cause partial urinary incontinence. The amount of the incontinence may depend upon the extent of the neurological lesion. The treatment is the same as complete incontinence in nervous system diseases.

Enuresis is a form of partial urinary incontinence resulting in bed-wetting and usually occurs at night during sleep. It is most often seen in children, but there are some adults who are afflicted with this disability. Diagnosis rests largely upon the history in which it is ascertained that the urine is lost at no other time. The etiology of enuresis in both instances is based upon psychoneurotic factors. However, organic lesions, such as congenital neurological abnormalties or ectopic ureter must be ruled out. In addition, complete urological studies must be made upon all patients with this complaint. Psychoneurosis as the sole factor cannot be stated as the cause until all other possible organic lesions are ruled out and the urinary tract is found to be normal. In such cases, the treatment then will depend upon good psychiatric management. The correction of any existing congenital anomalies, likewise, should be done if it is found the etiological factor of enuresis is due to this condition.

Stress incontinence in the female produces partial urinary incontinence. It may be defined as the loss of urine through the intact urethra under certain conditions which cause an increase in intra-abdominal pressure. Some examples are coughing, sneezing, laughing and under certain conditions certain types of emotions. It may be mild or severe.

The *types of stress incontinence are*:

I Congenital

II Acquired
- a. Postpartum
- b. Postmenopausal
- c. Postoperative

In order to have an understanding of the etiology of stress incontinence, a knowledge of the anatomy and histology of the urethra is essential. The urethra varies in length from 3 to 5 cm. with an average of 4.1 cm. The normal female urethra assumes an angle 16 degrees from the external to the internal meatus. In the lower 2/3 of the urethra from the internal meatus to the external meatus, the urethra is inseparable and an integral part of the anterior vaginal wall. Bulbo-cavernosi muscles lie along the lateral side of the urethra in the region of the external meatus. Adjacent, but more superior and more posterior along the course of the urethra, one finds the ischio-cavernosi muscles. Fibers from these muscles are at some points inseparable. Furthermore, they appear to be closely adherent to the tissues over the superior surface of the

urethra. The levator ani muscles, including the pubo-coccygeus portions are lateral to the urethra and their fascia adhere very closely to the external surface of the urethra.

On both sides of the urethra in the region of the juncture of the middle and upper thirds, many heavy, fibrous bands of tissue lie along the lateral wall of the urethra and the anterior vaginal wall to form a fibrous structure which inserts into the pubic ramus on both sides — "pubo-prostatic" or "pubo-urethral" ligaments.

*Etiology and Pathology of Stress Incontinence.* The pathology of stress incontinence probably occurs from two basic causes, which are frequently co-existent but in individual cases, one may predominate. These causes are: 1. Failure to maintain closure of the internal urethral orifice under conditions of exertion or stress. 2. Failure of the bladder or urethral supports (ligaments, fascia and muscles) in preventing descensus of the neck of the bladder and urethra under the above mentioned conditions of stress.

The exact nature of the mechanism of stress incontinence in all patients is not completely known in these two basic causes. The greatest difficulty arises in explaining satisfactorily the reasons for these failures of the internal urethral orifice or the bladder urethral supports. Certain factors, however, are probably present in the different types of stress incontinence. In the congenital type the mechanism is believed due to deficient innervation or congenital maldevelopment of the urethral or bladder supports. The post-partum stress incontinence is the result of obstetrical injury from lacerations and distortions of the internal urethral orifice and/or separation and laceration of the bladder and urethral supports. The post-menopausal type may be the result from atrophy of the bladder support (ligaments, fascia and muscles), previous obstetric injuries, and deficient vascularity of the urethra, particularly the "spongeosa" layer previously mentioned. The post-operative stress incontinence results from failure to understand thoroughly the anatomy of the urethra and its associated structures. This results at operation in either distortion of the internal urethral orifice, improper replacement or apposition of the fascia and muscles, or impairment of the blood supply of the urethra.

Ball and Jeffcoate have further demonstrated these causes by the use of lateral cysto-urethrograms showing the abnormal downward and forward displacement of the bladder neck and urethra, beneath the symphysis; i.e. failure of the supporting muscles and fascia.

*The Diagnosis of stress incontinence:*

1. History
2. Physical examination (this includes pelvic examination bearing in mind the possibility of vesico or urethral-vaginal fistula).
3. Urinalysis
4. Cystoscopy
5. Differential diagnosis

This includes all previous etiological factors mentioned as a cause of partial incontinence of urine.

6. Cysto-urethrograms
7. Urethral-elevation tests ("Marshall-Marchetti test")

*The Treatment of Stress Incontinence:*

1. Prophylactic
2. Non-operative
3. Operative

*Prophylactic Treatment.* The occurrence of poor bladder control in patients after delivery is frequently seen at the initial post-partum visit six weeks after delivery. Frequently, patients will complain of difficulty in holding their urine, or frequency of urination, urgency, or occasionally loss of urine on laughing or sneezing. These symptoms may be forerunners of the condition of urinary stress incontinence. At least they are signs of weakness of the muscles used to control bladder function, and also of weaknesses of the vaginal muscles. At this visit each patient should be examined carefully and taught to contract the perineal muscles, and instructed in an exercise which will strengthen the muscles of the birth canal. This can be taught by the physician, who, upon examination of the patient can instruct her to contract the vaginal muscles about the examining fingers. Many women are not conscious of this ability to contract the vaginal musculature, and must be instructed in this exercise. The sensation she must achieve is the same as though she were trying to contract muscles to stop the flow of urine or to check a bowel movement. With a little encouragement, patients will soon achieve this sensation and be able to perform this exercise. With the use of these resistive exercises, bladder tone will return to normal in the majority of cases. This should do much

to prevent the later occurrences of urinary stress incontinence. All patients are instructed to exercise the perineal muscles at certain intervals each day. A suggested regime is to complete 75 to 100 perineal contractions before arising and after retiring at night. It should become habitual in those patients with an awareness of function. In patients who do not have this awareness of function and co-ordination, these instructions may not be able to be followed. In this case a perineometer may be employed to advantage in this group. This visual and resistive mechanism is employed for the physiological exercises after careful instruction in its use. Further, prophylactic treatment should consist of careful conservative obstetric care prenatally, and sound judgment at the delivery. Careful emptying of the bladder by catheter at delivery and the use of the median episiotomy are helpful adjuncts in the prevention of injury to the bladder and the operation of the voluntary muscles that form the external urethral sphincter.

*Non-operative Treatment of Stress Incontinence.* (Physiological therapy). From the results obtained in various clinics, it is now believed that a patient with urinary stress incontinence should have the benefit of non-operative treatment, initially. Again, the patient is examined with the fingers in the vaginal canal and she is instructed to contract these vaginal muscles. (Pubo-coccygeus fibers of the levator ani). Again, these exercises are to be taught to her and, if necessary, the perineometer should be given a trial for a period of weeks or months, depending upon the results that are being achieved, and the progress that is being made to strengthen these muscles. Many patients with stress incontinence will improve upon non-operative treatment alone. However, if results of the exercise do not improve, then operative interference is indicated. This is particularly true in elderly cases who have lost all anatomical ability to strengthen the muscles of the urethra and vaginal wall.

*Operative Treatment.* In reviewing the different types of operations for the relief of stress incontinence, one will see the multiplicity of different techniques that are employed. This demonstrates that no one method has been devised which is successful for each and every case. Accurate estimates have been made that operative cures are probably not more that 50 or 60%, although most statistical studies have claimed as much as 80 or 90% operative cure for stress incontinence.

Basically, there are four different types of operative procedures that have been used for the cure of urinary stress incontinence in the female. In the employment of the various procedures, one of several mechanical changes is made: 1. The musculofascial sling is placed below the urethra. 2. Plication of the bladder neck muscle and/or urethra. 3. The urethra is lengthened or curved. 4. The urethra and/or bladder neck are returned to normal position behind the symphysis.

1. The musculo-fascial sling placed below the urethra: Many operations have been devised using a fascial or muscle transplant from some adjacent or contiguous structure about the urethra in order to give support to the urethra, tighten the fascial planes. These serve the purpose of voluntarily contracting the urethra when stimulated. The urethra becomes elevated and prevents the loss of urine upon the increase of intra-abdominal pressure. Such examples of this type of operation are the Aldridge procedure in which rectus-fascia straps are used, the Millen-Reed operation in which lateral rectus-strips are placed beneath the urethra from side to side, and the Studdiford operation, employing the use of fascial strip transplants.

2. Plication of the bladder neck muscle and/or urethra: This method decreases the size of the lumen and strengthens the fascial plane. Examples of this operative procedure are: The Kelly operation, in which shortening of the internal sphincter is performed with mattress sutures; the operation of restoring urethral sphincters with replicating the under surface of the urethra; and with the Ball procedure of plication of the bladder neck.

3. The urethra is lengthened or curved. This decreases the size of the lumen, strengthens the urethral tone by stretching of the urethra, and tightens fascial planes. Most prominent among these operative procedures is the Berkow-Para-urethral fixation operation. In this operation the urethra is advanced and angulated.

4. The urethra and/or bladder neck are returned to normal position behind the symphysis. This operative technique re-establishes the

urethro-vesico angle, tightens the fascial plains or supports, and lengthens the urethra. Under this procedure, a leading operative method today is the Marshall-Marchetti operation. This suprapubic vesico-urethral suspension employs the method of suturing the anterior vaginal wall to the periosteum of the symphysis on its posterior surface. This gives the effect of forming a hammock for the urethra and elevates and returns it up behind the symphysis in its normal position and restores the urethro-vesicle angle.

No definite or final pronouncements can be made on the subject for the relief of stress incontinence in the female, for the problems of this condition are not completely solved. However, certain answers can be given to the question of non-operative and operative procedures. Each patient must be carefully evaluated as to the etiology of her incontinence and the decision for operative intervention is made only after the conservative or non-operative treatment fails. The use of the conservative methods is advised at first, such as the physiological exercises. If these fail, then one of the operative procedures described may be utilized for the cure of stress incontinence.

**SUMMARY**

From the foregoing descriptions and studies of the various etiological factors causing complete or partial incontinence in the female, one can see the difficulties encountered in the diagnosis and treatment of this complex condition. One must bear in mind there are many factors involved and a careful history of the onset of this condition plus complete examination including a general physical examination, pelvic examination, neurological examination, cystoscopic and X-ray studies must be made. Then the type of procedure will depend upon the age of the patient, the pathological anatomy present, the previous operative work performed, and last, but not least, the skill and technique of the surgeon.

« « «  » » »

## Arthritis research

Efforts to produce experimental arthritis by immunization of animals with joint tissues have been made in several laboratories. McKee and Swineford immunized guinea pigs and rats with homologous joint and kidney tissue combined with heat-killed beta-hemolytic streptococci. No precipitating antibodies or pathologic abnormalities in joint or other organs resulted. Glynn and Holborow were able to cause a synovitis in rabbits by immunizing them with chondroitin sulfate from human costal cartilage combined with live beta-hemolytic streptococci. In view of the ability of beta-hemolytic streptococci alone to cause joint lesions in rabbits, this finding bears little significance. Favour and his coworkers recently followed the experimental nephrotoxic model somewhat more closely than has been done heretofore, in efforts to produce experimental arthritis. They immunized rabbits with guinea pig synovia. They also immunized guinea pigs with guinea pig synovia. Each type of experiment was done with and without adjuvants added to the synovial antigen. Antijoint serum fractionated to yield high potency material for intra-articular injection in a concentrated form was prepared. Both antijoint serum and the fractions of antijoint serum were tagged with $I^{131}$ and given either intravenously or intra-articularly to guinea pigs. No evidences of specific localization of the tagged materials on joint tissue and no synovial lesions were found in recipient animals. *Cutting B. Favour, M.D. et al. Arthritis Research. New England J. Med. June 7,* 1956.

# Tuberculosis Control 1956

**Edward A. Piszczek, M.D., M.P.H., Hinsdale**

DESPITE the fact that most lay individuals today do not consider tuberculosis very seriously, primarily because of the rapidly declining death rates, the medical profession knows that tuberculosis is still the Number One public health contagious disease problem in the United States.

In 1954 in the United States 100,450 newly reported cases of tuberculosis were recorded and a total of 16,392 deathes were attributed to tuberculosis in the United States. In the State of Illinois 6,361 new cases and 1,052 deaths occurred.

Despite the introduction of many new "miracle" drugs in the treatment of tuberculosis, isolation is still the primary weapon in the control and eventual eradication of this disease. It is only through providing sanatorium facilities for all known active cases of tuberculosis that infection can be greatly reduced amongst the younger population. The feeling that new tuberculosis drugs will control infection of others while the person circulates in the general population is creating a situation that is becoming more critical medically as the population loses its fear of the disease.

It is regrettable that in the State of Illinois we do not have separate security beds available for those who do not follow medical advice and leave the sanatoria against medical advice. At the present time all sanatoria operating in the State of Illinois are obliged to admit patients at their own request. No patient can be forced to remain in the sanatorium against his will. There are many alcoholics and narcotic addicts who should be forced to remain in the sanatorium and provision should be made at some time in the future for security beds where patients can be committed for care for the safety and protection of their families and other contacts.

There is every indication in local, state, and national statistics that the severity of tuberculosis is on the increase as evidenced by incidence in the younger group of bone, kidney, and tuberculous meningitis. Victims of tuberculosis who have taken drugs intermittently for a long time will develop drug resistant germs and when these are passed on to other individuals, treatment may not be effective because of the failure of the resistant germs to respond to the standard drugs used in tuberculosis today. There are reports of a number of cases of tuberculous meningitis in children caused by atypical tuberculosis organisms or new chromogenic strains of tuberculosis organisms which have proved rapidly fatal and non- responsive to therapy.

Despite the fact that the death rate in tuberculosis has been reduced almost 100% in the last five years, the incidence of tuberculosis remains about stationary and it is felt by many that the reduction in deaths from tuberculosis has about been stabilized.

The modern attack on tuberculosis can be greatly improved. One method of recognizing the disease earlier is by use of the mobile X-ray surveys.

Illinois is to be complimented on the extensive mobile unit surveys which are done in this state. Illinois ranked third in the nation in 1954 for total percentage of the general population X-rayed. Washington, D. C. was the highest X-rayed population with 30.1 average, the State of Washington with 23.2, and the State of Illinois 20.6, the national average being 10.1. Despite the fact that the total Illinois population surveyed is more than twice the national average, tuberculosis controllers and public health officers should not feel satisfied until 100% of the adult population is X-rayed yearly.

There is still a great deal of work to be done in the State of Illinois and especially in the Chicago metropolitan area before we shall feel satisfied that everything is being done. Despite the fact that over one million mobile unit survey pictures were done in the Chicago area last year as a case finding means, we should not feel

*Executive Director, The Suburban Cook County Tuberculosis Sanitarium District. 55th Street and County Line Road, Hinsdale.*

satisfied until every adult over fifteen has a yearly chest X-ray.

With the stabilization of the incidence of active tuberculosis this method of case finding is still productive; however, it is more productive to look for tuberculosis in sick individuals who are being admitted into the hospital. From our studies and observations of the past three years of hospital admission X-rays it is at least three times as fruitful to X-ray hospital admissions as it is in general community surveys.

I believe that the recent advances in the recognition and treatment of syphilis should make us consider the even greater benefits of the routine hospital admission X-ray program. I believe it is no longer necessary that every individual being admitted to the hospital have a routine Kahn test. It would be much more beneficial in the total medical picture of the individual to have a chest X-ray done routinely than to have a routine Kahn test for syphilis.

The experience of the Veterans Administration in 1954 in the routine examination of their patients on hospital admission and their employees is well recognized as an excellent case finding program. Their results show:

In 1954 the Veterans Administration surveyed 746,167 patients and found 1,926 active cases of tuberculosis (1 in 387) and 6,829 inactive cases of tuberculosis (1 in 109).

They also surveyed 244,128 employees and found 80 active cases (1 in 3,055) and 318 inactive cases (1 in 769).

The use of the tuberculin test in pediatric and general practices should be universally stimulated for the benefit of the patient and his family. Knowing a tuberculin positive status of the individual should alert that individual to periodic observation and medical supervision since it is in this positive group that tuberculosis occurs.

More than 40% of the total adult population living in the suburban Cook County area were X-rayed during the year 1955. The continued rise in community, school, industry, and hospital admission X-rays has increased the total number of minimal cases found in 1955 to 28.8% compared to the national average of 21.9%; has reduced the moderately advanced cases to 29.1% compared to the national average of 40.7% and far advanced average of 31%

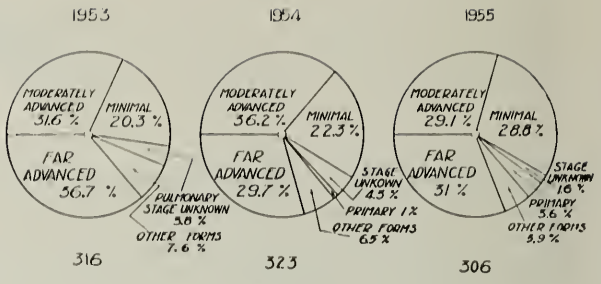



**Figure 1**

compared to the national average of 37.4%. (Figure 1)

The earlier discovery of cases has reduced the length of hospital stay from approximately one year in 1950 to about 236 days in 1955.

The alertness of the population to periodic chest X-rays whether done in industry, schools, community surveys or as hospital admissions should constitute the Number One health advancement towards the control of this crippling and killing disease and will lead to a speedier eradication.

Health department staffs have given priority in their work to the follow-up of all contacts to known active cases of tuberculosis. Their consistent routine of periodic X-ray examination has resulted in discovery of the disease in the early stage.

Out of the 306 new cases reported in Suburban Cook County in 1955, a breakdown of the 14 new cases picked up on routine contact follow-up by stage of disease reveals:

| *Far Advanced* | *Moderately Advanced* | *Minimal* | *Primary* |
|---|---|---|---|
| 2 (14.3%) | 4 (28.6%) | 6 (42.8%) | 2 (14.3%) |

## MORBIDITY IN TUBERCULOSIS

In new cases reported, Illinois has an attack rate of 54.9 per 100,000 population compared with the national average of 48.8, and is 36th in line of highest average.

A study of the morbidity rates in the states adjoining Illinois reveals:

| | |
|---|---|
| Illinois | 54.9 |
| Wisconsin | 28.8 |
| Michigan | 53.7 |
| Indiana | 35.7 |
| Kentucky | 83.4 |
| Missouri | 45.4 |
| Iowa | 16.0 |

Kentucky remains the only state consistently

to show a higher morbidity rate of those states adjoining Illinois.

## DEATH RATES IN TUBERCULOSIS

Illinois ranks 34th in the line of states as far as death rates are concerned, having a state death rate of 11.5 per 100,000 population: 18.9 in the larger cities and 6.2 downstate. The national death rate average is 10.2 per 100,000 population.

A study of the death rates in the states adjoining Illinois reveals:

| | |
|---|---|
| Illinois | 11.5 |
| Wisconsin | 6.0 |
| Michigan | 12.3 |
| Indiana | 9.1 |
| Kentucky | 15.1 |
| Missouri | 12.3 |
| Iowa | 3.2 |

Here, three states: Michigan, Kentucky, and Missouri have a higher death rate than the State of Illinois. This probably speaks well for our medical and sanatorium care of tuberculosis cases.

The present problems in tuberculosis control vary considerably from the problems encountered when the disease was the first cause of death in the early 20th century.

At the present time about two-thirds of all the newly reported cases of tuberculosis occur in the male sex. With the greater isolation of known active cases of tuberculosis, the improvement in infant care and better supervision of the health of the younger population, the age group attacked by tuberculosis has increased to beyond midlife. The average age of people who are attacked is in the middle 40's.

There are many areas in the United States that have specific public health problems of certain groups of the population. Among the common groups where the tuberculosis attack rate is high are: first, the displaced persons and refugees from foreign countries who have had a great exposure to disease and a lowered resistance by restricted diets; second, in the United States there are many areas where there is a fairly large Mexican-Indian-migratory worker population. This population group with known high incidence of tuberculosis requires specialized educational and case finding programs for the early detection of the disease. In order to control the disease in the general population, all groups which have a higher incidence should have concentrated medical and survey attention.

## DISCUSSION

When Wilhelm Konrad Roentgen discovered the X-ray in 1898 and made the X-ray machine possible early in the 20th century, it was felt that tuberculosis could be conquered within a generation because it could be detected early by periodic universal application of the X-ray.

Today, more than half a century later and after at least a dozen "miracle" drugs for the treatment and eradication of tuberculosis have been reported, tuberculosis is still the Number One public health contagious problem in the United States.

Illinois, through its medical and public health leadership, has taken a progressive part in looking for tuberculosis. Despite the fact that it has X-rayed twice as many people as the national average in mobile unit surveys, 20.6% of the total population, there is need for a more complete X-raying of hospital admissions and for a tuberculin testing program to accentuate case finding measures to find the disease in the earliest stage possible. No tuberculosis control officer or public health official will feel satisfied until 100% of the adult population is X-rayed yearly.

## CONCLUSION

Alerting the population to the fact that tuberculosis is still the Number One public health contagions problem should lead to greater participation in periodic chest X-rays whether done in industry, schools, community surveys or as hospital admissions.

In the State of Illinois in 1954 tuberculosis affected 6,361 individuals and 1,052 deaths occurred. Every effort should be made towards the control of this crippling and killing disease that will lead to a speedier eradication of it.

# Hospital Admission X-Ray Program

**Sister Mary Joan Weissler, Ad.PP.S., R.T., Red Bud**

## INTRODUCTION

WITHIN the past several years routine chest X-ray programs for hospitals have been given great impetus. A number of articles have been written in periodicals attempting to describe the causes for success or failure of such programs. It is my opinion that the routine chest program should be strongly encouraged because it is through a program such as this that any number and types of chest pathology are discovered which would otherwise escape detection.

Routine chest programs in many instances have been failures because of misunderstanding of the program by both the hospital personnel and the medical staff. Once it is properly introduced with co-operation continuing, there will be no gross disappointments. The directors and local officers of the Tuberculosis Association will readily lend assistance.

Our chief purpose in reporting the progress at St. Clement's Hospital in Red Bud, Illinois is to show how this type of program could be put in operation in every major institution in the state and throughout the country.

## THE PROGRAM

Our routine chest program was begun July 1st of 1951. Before launching into this new work it was considered from various angles by our Hospital Administrator, our Radiologist, and also by our staff physicians. Having decided that the program was very much worthwhile and possible in our set-up, we accepted the offer of the Illinois Department of Public Health made through Doctor Hall.

To make more clear to the doctors the purpose of this program, Doctor Bihss, our Radiologist, addressed a letter to them explaining that this was a screening program, not a diagnostic one. Doctor Bihss emphasized that the conventional 14x17 is far superior in diagnostic value to the miniature film and can never be replaced by it. The doctors were told that if chest pathology was suspected in any of their patients, the 14x17 was in order. They were also reminded that in keeping with the contract signed by the Hospital, admitted patients would be taken for the miniature chest X-ray either on admission or some time before discharge as soon as the patient's condition permitted.

From limited observation we knew of instances where programs similar to this have not been successful. It seemed that the chief cause of failure was poor interdepartmental relationship and especially lack of co-operation from personnel on the floors, for it is there that the patients to be X-rayed are found. To forestall anything like this, we endeavored to do two things:

1. To inform the key personnel of the aims and value of the program, and to make them feel that they were, at least in part, responsible for the success or failure of the program in our Hospital. (Here I might add that we always pass on to them any word of praise that may come to us because of their efforts.)

2. To maintain pleasant working relationships between the floors and the X-ray department. Assured of these, co-operation will follow.

In addition, those working in the X-ray department must be "sold" on the idea of the chest program. If they are not thoroughly convinced of the value and importance of the project, and enthusiastic in promoting the same conviction among the personnel of the other departments, the program is doomed to failure from the outset.

Here at St. Clement's the following system has evolved and has proved very satisfactory:

1. As soon as a patient is admitted, an admission slip is sent to every department. Every department knows who, where and why.

2. Every day at 4 p.m. someone from the X-ray Department has the Supervisor or Head Nurse of each floor check the slips we have in our department to see who is able to have the

*From St. Clement's Hospital, Red Bud, Illinois.*
*Introduction by Francis E. Bihss, M.D.*

chest X-ray taken that day. The Supervisor also indicates whether the patient is ambulatory or will need to be taken to the X-ray department by wheelchair or stretcher.

3. The chest X-ray is taken. The film number is temporarily recorded on the admission slips kept in the X-ray department and the slips are withdrawn from the group not yet X-rayed. This does away with confusion.

4. The individual from the Department who has "collected" the patients, stamps a red dot on the floor slips of the patients who have been X-rayed. She also puts a red dot on the slips of those patients who have had 14x17's, those who have been re-admitted within six weeks, and the very small children.

5. If a patient is ready to be discharged and the desk clerk on the floor notices that there is no red dot on the admission slip, she notifies the X-ray department by telephone. We take action as soon as we can. Sometimes this is quite inconvenient since we use the same X-ray tube for the chest unit as we do for general radiography. It calls for a bit more work, but since we do not wish to miss a single patient, we suffer the inconvenience.

6. As our charge slips we use the 4x5 film paper by merely writing the patient's name and "Chest $100." This saves on stationery.

7. The 4x5 sheet films are filed numerically in the Department. They are discarded after two years.

8. Our report form is simple. Only one copy is made for the patient's chart. In cases where the Radiologist has recommended a 14x17 and the patient has been discharged before the report gets to the floor, we make a second copy for the Doctor. In nearly all these cases the patients return for the follow-up examination.

9. A loose-leaf notebook is kept in the X-ray department containing mimeographed forms for the recording of necessary information: date, film number, patient's name, age, doctor; the radiologist's impression, and also if a 14x17 had been indicated. This form is simple and compact. Every six months, the sheets are transferred to permanent file.

We X-ray all patients, even the very short-stay patients (T&A). Who knows but that it may be one of these that has what we are on the look-out for. We did find a very active case once this way.

On the Admission Slip we get a fairly good hint of patient diagnosis. If there is a chest condition and no 14x17 is ordered, we wait. The order usually comes. The doctor must be given time. This does not occur too frequently.

One of our major considerations at the outset of the program was the fear that the miniature film would tend to supplant the conventional 14x17 as a diagnostic procedure. The following spot-check on the month of January over a period of nine years proves that our fears were not justified.

JANUARY

| Year | Total Chest (14x17) (In and Out) | Adult Admissions |
|---|---|---|
| 1948 | 9 | 66 |
| 1949 | 11 | 96 |
| 1950 | 42 | 120 |
| 1951 | 45 | 144 |
| Routine Chest Program initiated July 1, 1951 | | |
| 1952 | 56 | 168 |
| 1953 | 88 | 214 |
| 1954 | 51 | 247 |
| 1955 | 80 | 239 |
| 1956 | 98 (60 in-patients) | 199 |

1955

| | |
|---|---|
| Admissions | 3894 |
| Newborns | 767 |
| Pediatrics | 395 |
| Deaths | 121 |
| Re-admissions (Witin 6 wks.) | 279 |
| 14x17's (Does not include outpatients nor re-X-rays of inpatients) | 490 |
| Photofluorographic chests | 2303 |
| Personnel | 151 |
| Patients | 2152 |
| Not taken ("slips") or 1.7%* | 37 |

*The figure, 37, the actual number of patients not photofluorographed during the year 1955, is used to determine percentage in preference to the subtraction method since there is much overlapping of figures. Some newborns are X-rayed, 14x17's are obtained on a fairly large number of patients by direct order, etc. Most of the pediatric group have had either conventional chest films or routine chest films.

## SIDELIGHTS OF THE PROGRAM

1. All of our doctors have become more chest-conscious and we have more, not less, di-

rect ordering of 14x17's. Many of the doctors make a special trip to the X-ray department to learn why the item "Non-tuberculous pathology" had been checked and yet no 14x17 recommended.

2. With few exceptions, patients who were discharged from the hospital before the doctor saw the routine chest report and for whom a 14x17 had been recommended, return for the film.

3. In the 4½ years that this program has been in action, I recall only two patients who refused the chest X-ray. One of these was intoxicated and the other an unusually stubborn one.

4. Many of the patients inform others of the chest program. This is particularly noticed on the Maternity Floor. They advertise the program among themselves.

5. One of the doctors expressed himself in saying that as a routine order he believed the routine chest to be of greater value than routine urinalysis and blood count.

6. Our program, for the most part, has been worked up to such a point that we need not actually wait for a written order for a 14x17 if the Radiologist has recommended one. However, we feel that it is more courteous and generally more prudent to wait.

7. Of the number of cases of pathology found each month with this program, tuberculosis certainly takes a "back seat". There is a large variety of pathological findings each month. We average from 35-40. Last month we had 60. Not all of these findings, however, are of a serious nature.

8. The really impossible cases are relatively few, about three or four cases a month in our hospital. Not all the patients we X-ray are ambulatory. We take the trouble of bringing them to the department by stretcher or in wheelchairs if they cannot walk. It is among these that we get a fair percent of 14x17 follow-ups. So don't neglect the wheelchair or stretcher groups. The moderately difficult patients (the chronics) we take on some relatively dull afternoon. Usually the supervisors on the floors help us with these patients.

9. We have found that it is not good to overlook the children who are co-operative enough. Interesting pathology has been found in this age group.

10. Here and there a doctor will want to introduce an innovation, e.g., sending an outpatient for a 4x5 chest. This type of thing can be brought to a stop at the very onset by gently reminding the doctor of the purpose of the program.

## CASE REPORTS

1. A thirty year old married woman with several small children was admitted to have surgery done on her jaw which was thought to be an osteomyelitis. A 4x5 chest film was taken at the time of her admission. An unusually large hilar node was reported. A 14x17 followed. Later she had pelvis and skull X-rays. These revealed that she had metastases to both with a pathological fracture of one of the femurs. She was given P-32. She comes periodically for check-ups. Her fracture is healed. She no longer limps. The metastatic areas have grown smaller. This story began in August of 1953. Several weeks ago doctor made the notation "Amazing!" on her therapy card.

2. A young lady in her early 20's was admitted for a tonsillectomy. Through this chest program she was proved to have numerous cavities from apex to base. I was present when she was quizzed by both her physician and the Radiologist. There was not an inkling that would lead one to believe that she had very active, far-advanced tuberculosis.

3. A middle aged man came to the hospital just a matter of weeks ago with what was thought to be an acute gall bladder attack. A consultant surgeon was of the same mind. An order for a plain film of the abdomen was carried out and at the same time the 4x5 chest film was taken. And there was the trouble — pneumonia! Following this, we not only received orders for a 14x17 chest, but also for a gall bladder study and a complete G-I series. And all because of the little 4x5.

## CONCLUSIONS

1. This chest program has so become a part of our hospital routine that we would not think of parting with it. It does so much good. It is more than a tuberculosis program. We hear many compliments and expressions of gratitude from the patients. Many become worried if they think they might be overlooked. They inquire.

2. After one sees this type of program working for several years one cannot help having personal satisfaetion in having been an instrument for good. If only one or two eases of major pathology are diseovered eaeh month, it eertainly justifies the program.

3. On the other hand, one should not drive the good thing to excess by repeating the chest X-ray at very short intervals, as for instance, on maternity patients who may eome in and out several times before delivery. At St. Clement's we do not take obstetrical patients until after delivery and that for several reasons. For one thing, it is diffieult to set up a routine for them until after that time.

4. About three eseape our ehest program eaeh month. Little slips are made somewhere. We hope that one of these months we will aetually reaeh 100%. We are trying. One should not become discouraged and discard the program if several are missed now and then. It is too worthwhile a program.

5. To make the program a sueeess there must be a spirit of saerifiee and eo-operation. All personnel in any way conneeted with the program must believe in it. This is especially true of the personnel of the X-ray Department, for their attitude will influenee the whole. If they eannot be bothered, why should others?

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## Treatment of osteoporosis

It has been our practiee, once a diagnosis of osteoporosis has been made, to initiate treatment in female patients with both an estrogen and an androgen. Diethylstilbestrol (stilbestrol), which is inexpensive and can be administered by mouth, is the estrogen most eommonly employed, in doses varying from 1 to 5 mg. daily for four or five weeks, then omitted from seven to 10 days.

Methyl testosterone, in linquets, is the male hormone most frequently administered to our patients. In women, treatment usually is started with 5 to 10 mg. daily or every two days and continued four to eight weeks or until signs of masculinization become troublesome.

In men, treatment usually is begun with both estrogen and androgen. The androgen is continued indefinitely and the estrogen until side effects become disturbing. Two or 3 10 mg. linquets of methyl testosterone may be given daily or, if injections are preferred, 50 mg. of testosterone propionate three times weekly. The long acting testosterone esters — tesosterone cyclopentylpropionate, testosterone enanthate, and so on — may be given in doses of 100 to 250 mg. every two to four weeks. Estrogen, most often stilbestrol in doses of 1 to 2 mg. daily, usually is well tolerated for one to two months before mastodynia, gynecomastia, or decreased libido occurs. As with testosterone in women, combined therapy may be tolerated for prolonged periods or indefinitely without untoward effect. In the hormone-treated male, prostatic examinations should be made regularly and determinations of the acid phosphatase from time to time may be reassuring. *Marc Moldawer, M.D. Pathogenesis and Treatment of Senile Osteoporosis. Geriatrics. Aug.* 1956.

# An Outline for the Treatment of Severe Burns

**Richard J. Bennett, M.D., and Norman C. Meyer, M.D., Chicago**

ALL BURNS which involve more than 10 per cent of the body surface must be considered serious, and a strict outline of treatment instituted. This treatment may be set up and carried out in three phases. They are as follows:

I. Immediate treatment
II. Short range treatment
III. Long range treatment

## IMMEDIATE TREATMENT

Place the patient on a sterile sheet and remove all clothes. The most important single decision is to quickly estimate the percentage of the body surface burned. The following outline will aid in making a rapid estimate:

| | |
|---|---|
| Head and neck | 9% |
| Right arm | 9% |
| Left arm | 9% |
| Perineum | 1% |
| Trunk front | 18% |
| Trunk back | 18% |
| Right leg | 18% |
| Left leg | 18% |

If over 10 per cent of the total body area is involved, anticipate shock and treat as follows:

1. Preliminary drugs (adult doses)
   Luminal sodium,® gr. 5 or
   Amytal sodium® gr. 3
   We do not use morphine in burn cases.
2. The surgeon and his assistants should be prepared with caps, masks, sterile gowns, gloves and instruments. All other personnel in the room, including the patient, should wear caps and masks.
3. Remove charred and loose tissue.
4. Puncture blisters.
5. Flush burn with sterile physiological saline solution. If grossly contaminated, wash gently with white soap and water.
6. Apply strips of fine mesh vaseline gauze.
7. Apply a fluffy cotton dressing.
8. Apply an elastic pressure bandage.
9. Splint all burns of the hands.
10. Use open vaseline treatment for face and perineum.

It is very essential to have primary laboratory work as a basis for comparison for all future laboratory work. In this manner we will be able to treat the patient intelligently through a serious situation.

## IMMEDIATE BLOOD WORK RECOMMENDED

(25-30 cc. blood)

1. Blood hematocrit
2. Blood hemoglobin
3. Complete blood count
4. Blood type
5. Blood cross match
6. Blood culture
7. Blood chlorides
8. Blood sodium
9. Blood potassium
10. Blood $CO_2$ combining power
11. Blood urea nitrogen
12. Blood total proteins

The blood hematocrit and blood hemoglobin should be done several times during the first forty-eight hours. After the first few days, it will be wise to follow up with blood cultures at intervals and run sensitivity tests on any bacteria identified.

Depending on the patient's course, blood chlorides and $CO_2$ combining power may be essential during the first few days. In the later treatment stages, blood counts, blood urea nitrogen and blood proteins will be of value. When the blood serum albumin levels off, the best way to remedy this condition is actual blood plasma or serum albumin which may be bought commercially.

## SHORT RANGE TREATMENT

Now that the immediate crucial needs of the severely burned patient have been cared for, we prepare for the next forty-eight hours. Careful consideration of the patient's many signs and symptoms and interpreting the necessary laboratory findings will aid in charting the patient's

course through a perilous journey. The greater the extent and depth of the burn, the more rapidly will the signs and symptoms change.

1. Introduce an INDWELLING CATHETER into the bladder.
2. Record *quantity* of urine every hour.
3. Record specific gravity every hour.
4. Penicillin, 600,000 units I.M. and daily until the open wound is closed, or change to another antibiotic as indicated by sensivity tests.
5. Tetanus antitoxin, 5,000 units, or booster dose of tetanus toxoid, whichever is applicable. Take the usual precautions for sensitivity.

Introduce a canula into a vein and tie in place for the following:

a. Blood transfusions
b. Blood plasma
c. Normal saline
d. Glucose solutions

Basically, blood transfusions are of the greatest value, but blood plasma is almost as valuable as whole blood. Normal saline should only be used to keep the intravenous tubing open and run very slowly when used. Glucose solutions are of value when the short range treatment runs more than forty-eight hours and the patient is unable to take nourishment by mouth. The quantity of plasma and blood given will depend entirely upon the surgeon's judgment of the clinical picture. The patient's urine, blood, and symptoms should be carefully evaluated at very frequent intervals.

Anticipate that the patient will vomit.

Allow 200 cc. of cool fluid per hour, orally.

A satisfactory fluid is:

| | |
|---|---|
| Tap water | 1,000 cc. |
| Table salt | 1 teaspoonful |
| Soda bicarbonate | ½ teaspoonful |

If the patient does vomit, stop all fluid by mouth and introduce a nasal tube into the stomach. Aspirate retained fluids. Introduce fluids and special feedings. The greater amount given by mouth means less intravenously.

**CLINICAL SIGNS AND SYMPTOMS**
(Dehydration)

Urine — Concentrated
Quantity less than 40 cc. per hour.
Blood — Hematocrit high (above 45)
Hemoglobin high
Symptoms — Pulse rate high
Apprehension
Restlessness
Thirst
Unco-operative
Confused
Drowsy
Blood pressure falls late

We can see in the state of dehydration that the urine and blood are concentrated and the clinical signs and symptoms are very specific. Change these findings as quickly as possible by giving more plasma and blood intravenously. Yes, plasma and blood are best to return the concentrated urine to normal specific gravity and raise the quantity excreted per hour. At the same time that this is accomplished the blood hematocrit and hemoglobin will decrease to more reasonable levels, and the clinical signs and symptoms will more nearly approach normal. Bloood transfusions and blood plasma in the ratio of two plasma to one blood are of the most value.

**CLINICAL SIGNS AND SYMPTOMS**
(Water Intoxication)

Urine — Watery and pale
Quantity 100—200 cc. per hour
Blood — Hematocrit low (under 40)
Hemoglobin low (under 12 gm.)
Symptoms — Pulse rate high
Apprehension
Restlessness
Not thirsty
Unco-operative
Drowsy
Pulmonary edema
Cerebral edema

In this instance too much fluid has been given and the total amount of fluids given should be materially decreased or practically stopped until the normal findings of the urine and blood as well as the clinical signs and symptoms are nearly approaching normal.

**CLINICAL SIGNS AND SYMPTOMS**
(Normal)

Urine — Straw, specific gravity 1.020
Quantity 40-60 cc. per hour
Blood — Hematocrit 40-45% cell pack
Hemoglobin 12-14 gms.
Symptoms — Stable full pulse 72-80
Blood pressure normal for the patient
Quiet
Co-operative
Not thirsty
Taking fluids well
Taking food well

We can see from this outline that the urine, blood and the clinical signs and symptoms are those of a patient who is doing well and all of the findings are approaching normal. This is the ideal to strive for. The patient may need oxygen for cynosis or respiratory distress.

These are the short and long range normal laboratory findings:

| | *Mg.* 100 *cc.* | *MEq/L* |
|---|---|---|
| Blood chlorides | 365 | 103 |
| Blood sodium | 326 | 142 |
| Blood potassium | 20 | 5 |
| Blood urea nitrogen | 10-15 | |
| Blood protein, total | 6-0-8.2 | |
| Blood albumin | 4.6-6.7 | |
| Blood serum globulin | 1.2-2.3 | |
| Blood $CO_2$ combining power | 50-80 vol. % | |

**LONG RANGE TREATMENT**

(Usually after 48 hours)

1. Remove urethral catheter when the clinical signs and symptoms and laboratory findings appear normal.
2. Give barbituate sedative.
3. First redressing (3-10 days) indicated by saturated dressings and bad odor.
4. Continue sterile technic in wound redressing. At this time a more accurate estimation of burn extent and depth may be determined. A primary excision of the burned area should be considered in some cases to shorten convalescence.
5. Debridement of dead and loose tissue.
6. Estimate when the first skin graft may be done.
7. Close all open wounds with skin as soon as possible.
8. Use blood transfusions 1-3 times weekly as indicated to compensate for blood loss.

**SKIN GRAFTING**

1. Operating room.
2. General anesthesia, if indicated, or sedative with local anesthesia.
3. Sterile technic.
4. Wound prepared with physiological saline cleansing.
5. Donor site prepared and graft removed.
6. Split thickness graft sutured in place.
7. More burn areas debrided and prepared for grafting.
8. Fine mesh vaseline gauze over graft and donor areas.

**DIET**

1. High protein-high calorie.
2. 2,000 cc. of fluid daily.
3. Vitamin supplement of:
   Vitamin A, 5,000 units daily
   Vitamin C, 1,000 units daily
   Vitamin D, 400 units daily

**CAUSE OF DEATHS**

1. Dehydration.
2. Water intoxication.
3. Septicemia.
4. Toxemia.
5. Respiratory complications.

Burn cases are being treated more intelligently today than in the years past, but our mortality and morbidity can certainly be much improved. It is becoming more and more certain that the conscientious surgeon can pull the severely burned patient through the immediate and short range portion of this treatment. We know that children or young people who have more extensive burns will probably survive, whereas the elderly, severely burned patient has a more serious outlook.

If all the hurdles have been passed successfully during the earlier stages, then, as the days go by, we become more and more watchful for septicemia and toxemia. By using meticulous surgical technic, insisting upon adequate food intake, and getting the wound closed, *infection, septicemia, toxemia, poor nutrition, morbidity and deaths will be minimized.*

208 S. La Salle St.

# Anesthetic Considerations of the Acutely Injured Patient

**Colonel Harvey C. Slocum, M.C., U.S.A. and**
**Lt. Colonel John A. Jenicek, M.C., U.S.A.**

ALTHOUGH the care and treatment of the soldier wounded in combat is the chief concern of the military physician, the non-battle casualty is a contsant source of trauma requiring medical attention. The vehicular accident is a major source of injury and cause of death. The magnitude of this problem in the Armed Forces is parallel to the nation-wide problems of traffic injuries and fatalities.

Department of the Army (CONUS) statistics for 1955 revealed an alarming number of fatalities caused by vehicular accidents. By making a maximum effort through enforcement and education, the Army has reduced the number of on-duty fatalities to a minimum. In Army fleet operation of vehicles the accident rate is 1.3 per 100,000 miles. This is below the national average. A fatality rate of 6.9 deaths per hundred million miles (all persons involved) is only slightly higher than the rate for the nation[4]. By contrast, 74% of military fatalities (1955) from all causes were due to vehicular accidents, and of this number 93% involved privately owned cars. It is apparent that the use and abuse of privately-owned automobiles during off-duty hours is beyond military control.

The facts presented indicate the scope of the problem of the military physician. The anesthesiologist who is trained to care for battle casualties is faced with similar problems in the treatment of the acutely injured victim from a vehicular accident. As a member of the surgical team responsible for the care of the acutely injured. the functions of the anesthesiologist in the preanesthetic phase of treatment include resuscitation, shock therapy, pain relief and preoperative evaluation. In all of these, he is well qualified to participate or advise.

In the series of injuries due to vehicular accidents reported by Zollinger[5], 77% of those admitted to the hospital were treated for some degree of shock. In the category of primary or neurogenic shock, one must also consider the severe psychic trauma associated with some injuries, e.g., an eye injury with the fear of possible permanent loss of vision. The vigorous treatment of shock, whatever the cause, is of lifesaving importance.

In all patients, a suitable vein is cannulated as soon as possible with a large bore needle, by cutdown if necessary. Electrolytes, plasma volume expanders or blood are administered in an attempt to correct any circulatory deficit. It is vital to re-establish as many of the physiological compensatory mechanisms in the patient as is possible before attempting surgical procedures. The existence of active or uncontrollable bleeding is usually considered as the only reason for immediate surgical intervention. Even in these cases a channel for the rapid intravenous administration of blood and other solutions is mandatory.

During the resuscitative phase of treatment, the use of opiates and barbiturates should be withheld because of the depressant effects on respiration, circulation and other vital functions. These are already depressed by the trauma and shock. However, in cases where the degree of pain aggravates the circulatory depression, it is logical to administer a small dose of opiate (5 or 10 mg. morphine). The patient who is restless or anxious, but not in acute pain, is treated with a small dose of barbiturate; e.g. 30 mg. of secobarbital. Using the intravenous route of administration, medication is given slowly to the point of optimum therapeutic effect without oversedation or depression. Preanesthetic medication

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*Presented before the General Assembly, Illinois State Medical Society, 116th Annual Meeting, Chicago, May 15, 1956.*

is limited to the use of atropine or scopolamine.

During resuscitation, the anesthesiologist makes a complete evaluation of the patient by examination and observation. This is supplemented by the findings of a complete physical examination made by the surgeon. It will determine the presence of pre-existing disease, physiological disorders or drug therapy which, in some instances, cause automobile accidents. Alcoholism, cerebrovascular accidents, or coronary occlusions may cause coma. Excess or lack of insulin in the diabetic, the use of antihistamines and certain other drug therapy may contribute to the cause of accidents. Cortisone therapy during the previous six months may indicate its use for preoperative or postoperative support of circulation. To discover these facts, a careful investigation by the physician-anesthetist is required. Complicating factors such as food or fluid in the stomach or a distended bladder are eliminated. At least one hospital in the District of Columbia considers this period of resuscitation and evaluation so important that it requires the patient to be in the hospital at least one hour before surgical intervention may be attempted.

The primary purpose of this paper is to discuss the evaluation of the acutely injured patient as it is accomplished, by anatomical region, and to consider complications and anesthetic implications relevant to the patient's injury. Mention is made of methods or techniques used by the anesthesiologist to cope successfully with these problems.

Head injuries constitute about 40% of all injuries seen[1]. Intracranial trauma produces complications with which the anesthetist is concerned. Increased intracranial pressure, with or without loss of consciousness, may cause a derangement of the vital signs. This occurs as a result of pressure upon the vital centers with depression of respiration, circulation and pulse changes. The anesthetic implications include restriction of opiates which may mask vital signs. The maintenance of an open airway and adequate ventilation are necessary for oxygenation and to prevent carbon dioxide accumulation. When the function of the respiratory center is severely depressed, artificial respiration may be necessary and will have to be maintained until the effects of the trauma are corrected or the patient dies. In certain cases, it is important to observe these patients for at least eight hours to determine the degree of brain damage present before deciding upon an operative procedure. Motor paralysis not involving the respiratory tract presents no special difficulties during anesthesia. The depressant effect of anesthetic drugs on the vital centers restricts their use to minimum quantities. Many of these patients are operated upon under local anesthesia. The relief of a subdural hematoma in this manner may permit the patient to regain consciousness during the surgical procedure. A light general anesthesia may be necessary to keep the patient quiet on the operating table.

Trauma involving the ears may be accompanied by evidence of bleeding or serous drainage from the ear canal. It is important to determine whether or not these findings are a sign of basilar fracture of the skull or only extensive damage involving the external or middle ear.

Patients who suffer eye injuries may be in extreme pain. Almost all of those who are conscious, experience severe psychic trauma because of the inability to open the lids or due to a temporary loss of vision. The penetrating injury of the eye may be complicated by intracranial penetration through the base of the orbit, and this must be carefully excluded. The anesthetic management of these cases requires early sedation with careful handling of the patient to minimize motion of all kinds. Surgical intervention is best accomplished within a four to six hour period and the choice of anesthetics is the use of a local block, both of the cornea and deep structures of the eye. The avoidance of coughing or straining in these patients is desirable to prevent disruption of the fluid chambers of the eye. To the anesthetist, eye injury represents a loss of vital eye signs, which often serve as a guide to the depth of anesthesia.

Maxillo-facial injuries present the problem of superficial and bony damage of the face and jaws. Extensive damage may involve the tongue and large vessels of the neck. These are a serious problem from the time of occurrence since the airway may be involved directly or there is danger of aspiration of blood and mucus from the site of injury. A tracheostomy may be mandatory for reasons of survival and if present will facilitate administration of anesthesia. The use of endotracheal techniques is indicated in all

maxillo-facial surgery. Pressure dressings to the neck must be applied in such a manner as to avoid the reflex areas, the stimulation of which would cause variations in pulse and blood pressure.

Injuries to the neck constitute about 5% of those seen. These injuries include soft tissue damage, chip-fractures of cervical vertebrae[3], fracture dislocations of cervical vertebrae with or without spinal cord damage, fractures of the trachea or larynx and crush-injuries involving the vocal cords and tracheal rings. Spinal cord damage near the level of the fourth cervical nerves may cause loss of diaphragmatic control of respiration. In the management of neck injuries, primary consideration is given to maintenance of an open airway. A minimum of motion of the patient's head is indicated in order to prevent further skeletal or spinal cord damage. For this reason, any attempt at endotracheal intubation must be very carefully managed. Many of these patients are placed on a Foster frame and ice-tong traction is applied to the head. Laminectomy may be performed under local anesthesia with the patient remaining in traction throughout the procedure.

Injuries to the thoracic and lumbar spine present anesthetic considerations when the sympathetic nerves are involved particularly with a loss of vasoconstrictor tone below the site of injury. A vasopressor drug may be necessary to insure maintenance of an adequate blood pressure.

In penetrating wounds of any paravertebral region which involve sympathetic fibers, the use of intravenous alcohol or local block may be necessary to relieve pain. Pain due to injury of the sympathetic fibers is not usually relieved by the opiates alone.

Injuries to the thorax represent 14% of all those seen following accidents and are fatal in 25% of the cases.[2] Minor wounds of the chest may be closed using a procaine block of the intercostal nerves. Surgical correction of major trauma, usually because of intrathoracic hemorrhage, requires general anesthesia using endotracheal techniques. The most important considerations are the control of the airway and motion in the lung field during surgery. An excess of positive pressure to the lung fields through the endotracheal tube decreases the return of venous blood to the heart resulting in decreased cardiac output and circulatory depression. When there is damage to the tracheo-bronchial tree, the use of excessive positive pressure may cause peribronchial dissection of air into the mediastinal area. The resulting mediastinal emphysema may cause anatomical distortion of the structures within that compartment and further embarrass circulation and ventilation. If this condition occurs and is undetected or untreated, the effects are similar to those of a bilateral tension pneumothorax. In the case of a lacerated lung, where clotting has sealed off a major bleeder, the use of positive pressure breathing to expand the damaged lung is contraindicated to lessen the possibility of further bleeding. Patients with asthmatic or allergic tendencies may present special problems in ventilation during anesthesia. Both thiopental and cyclopropane which tend to exaggerate these difficulties are to be avoided. Surgical procedures of the lung field involving the hilar structures may be expected to initiate autonomic reflexes causing both respiratory and circulatory depression. These reflexes may be avoided by the use of a deeper plane of anesthesia or the injection of a local anesthetic agent into the hilar region. Consideration must be made of those patients suffering from pre-existing pulmonary disease which reduces their vital capacity. High oxygen content of the anesthetic mixtures and adequate ventilation must be assured.

In the closed chest injury, fractures of more than two ribs will cause some inhibition of pulmonary function. The possibility of bone fragments penetrating lung tissue thereby causing hemo — or pneumothorax must be considered. Steering wheel contact may crush the chest cage producing a flail-type action and consequent inefficient respiration. When tension pneumothorax exists in a closed chest, positive pressure breathing is contraindicated because it will increase the degree of pneumothorax. Tension pneumothorax with mediastinal shift and acute circulatory embarrassment may cause death if not detected and relieved before any surgical procedure is attempted.

Rupture or tear of the diaphragm results in abdominal viscera being forced into the chest cavity. This destroys the balance of thoraco-abdominal pressures with a decrease in respira-

tory vital capacity. There is a decrease in the force-pump action of the diaphragm and consequent decrease in venous blood return to the heart. The repair of this injury is an indication for controlled respiration which allows the diaphragm to function only under control of the anesthesiologist. Inhibition of diaphragmatic movement during surgical repair greatly facilitates the procedure.

Abdominal injuries constitute five per cent of the total seen. The non-penetrating types may be complicated by rupture of visceral organs such as the liver, spleen or kidneys. Tears of suspensory ligaments and of the mesentery may cause hemorrhage, thrombosis and ileus. Shock as a result of concealed hemorrhage exists in varying degrees depending upon the severity of the injury. Administration of anesthetic drugs for surgical correction causes partial loss of splanchnic control of the vessels to the viscera with further pooling of blood and an increase of the shock factor. Spinal anesthesia is contraindicated in these injuries for this reason. If a loop of gut were ruptured, the contraction of the intestinal tract caused by spinal anesthesia would cause more contamination of the peritoneal cavity. The best anesthetic management of acute abdominal injuries may be accomplished by the combination of a field block with light general anesthesia. Relaxation is accomplished by the cautious use of one of the muscle relaxing drugs. An endotracheal tube is mandatory not only to insure adequate ventilation but to protect the airway from any possible spill-over of gastric content into the trachea.

Two per cent of injuries involve the pelvis and are crushing in nature. They may involve the urinary bladder, urethra, ureters or other pelvic organs. Shock, hemorrhage, and urinary contamination complicate these injuries. Manipulation of the pelvic girdle or any bony structure may produce or aggravate circulatory depression if the anesthesia is not deep enough to block undesirable reflexes.

Trauma to the extremities constitute 37% of the total. A compound fracture of the femur is probably the most painful and shocking of these injuries. Surgical procedures for the care of fractures may be accomplished under general or regional block anesthesia. All fractures of the extremities, open or closed, may produce neuromuscular or neurovascular complications. The relief of pain and vasospasm in the extremities may be accomplished by somatic and sympathetic blocks during the preoperative or postoperative periods.

Patients receiving burns, after acute circulatory depression from trauma has occurred, present a far more serious picture than those having either burns or trauma alone. The proper time for surgical intervention in the burned patient is a controversial subject. First he must be treated by replacement of colloids, electrolytes, fluids and protein in order to establish and maintain a safe circulatory balance. A small amount of opiate may be administered intravenously to relieve pain but should be limited, if possible, to exclude central depression which will add to the picture of shock.

Modern concepts in the treatment of burns eliminate any procedure which might require anesthetic drugs until after the patient has recovered from the primary effects of shock. When dressing changes, debridement and skin grafting are indicated, it must be remembered that the physiological compensatory mechanisms may not be restored for many months. For this reason, only analgesic concentrations of the anesthetic drugs usually used should be administered. The use of the opiates and barbiturates as preanesthetic medication generally is contraindicated because the depressant effects of these drugs far outlasts the effect of inhalation agents. As a result of depression and nausea, the patient fails to receive adequate metabolic support of food and fluids. The time factor in relation to any operative procedure on a burned patient is of great importance. This is demonstrated in the degree of postoperative circulatory depression exhibited by the patient and is in direct relation to blood loss and depression of the vasoconstrictor mechanism by anesthetic drugs. In many instances, the patient's blood pressure and pulse rate do not return to normal levels for 24 to 48 hours after a prolonged procedure in spite of one or more transfusions.

In consideration of surgical intervention, undoubtedly, the most important factor is the general condition of the patient rather than any specific area of trauma. The primary principle of saving life over limb indicates that the patient's general condition may be of more signifi-

cance than as to how long a tourniquet has been in place on an extremity. Experiences gained in Korea and other battle areas have indicated that anesthetic drugs injudiciously administered to the severely traumatized patient may in themselves tip the physiological balance with fatal results. It must be strongly emphasized that the volume and concentrations of depressant drugs usually used for anesthesia and pain relief in the care of the average surgical patient must be decreased to absolute minimums in those patients who have suffered from acute hemorrhage, traumatic shock and depletion of physiological compensation.

During the postoperative period, the same considerations, namely, the judicious use of opiates, the maintenance of electrolyte and fluid balance and the proper control of the airway must be closely supervised.

The respiratory, neurocirculatory and metabolic status of the patient must be supported until the compensatory mechanisms can recover from the insult of trauma, anesthesia and surgery. Unless this is done, the efforts to provide proper resuscitation, good anesthesia and adequate surgery will have been wasted.

New drugs and techniques continue to be introduced into the field of medicine for the care of surgical casualties. The old techniques of anesthesia by freezing having been revised to a point where the entire body may now be cooled to levels of 10 to 20 degrees F. below average body temperature. The resulting reduction in metabolism of the tissue permits the saving of life and limb that might ordinarily be sacrificed. Drugs used to produce carefully controlled levels of hypotension can be responsible for the saving of considerable amounts of the patient's blood during extensive surgical procedure where hemostasis is difficult to control. Ganglioplegic drugs such as chlorpromazine are being used experimentally and clinically in acutely traumatized patients in an effort to minimize the circulatory incompetence and prevent shock. Further research in the chemical components of epinephrine and their effects on the arteriolar bed promises to contribute something worthwhile in the study of shock. Significant research in the field of corticosteroids has produced a form of cortisone which can be administered intravenously by slow continuous drip when indicated for supportive therapy. Further research in the phenothiazine and steroid compounds gives us a hint as to the possibilities of new analgesia drugs which may be administered for the relief of pain without loss of consciousness.

Beginning with resuscitation and continuing during anesthesia, surgical intervention and the early postoperative period, the anesthesiologist rightfully assumes the role of guardian of the patient's welfare. He is often taxed to the limits of his professional ability to compensate for the problems encountered by the acutely injured patient, but because of his knowledge of respiratory and neurocirculatory physiology and pharmacology, he is the physician most able to provide for the needs of the patient.

The medical profession is ever seeking new and improved methods for the relief of human suffering. In contrast, it would appear that the tremendous progress in the mechanical age still surpasses our best efforts to save lives.

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# The Anemias of Pregnancy

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ANEMIA is undesirable during pregnancy for several reasons. It impairs the health of a gravid woman, predisposes her to infection and increases her susceptibility to shock in the event that considerable blood is lost during delivery. By impairing the oxygen carrying capacity of the blood, it may reduce the effiiciency of the uterine musculature and prolong labor.[1] Anemia has been thought by some to increase the incidence of puerperal complications.[2,3] It may cause undernutrition of the fetus and it may limit iron storage in the fetus to such an extent that anemia results in the child after birth.[3,4] It is important, therefore, that anemia occurring during pregnancy be recognized and corrected.

## PHYSIOLOGICAL HEMODILUTION

It is a well established fact that the blood volume increases during pregnancy. Both the plasma volume and the red cell mass increase, but the plasma volume increases to a greater extent than the red cell mass, thus giving rise to a relative hemodilution.

The plasma volume, as determined by T-1824 dilution studies,[5] shows a significant increase by mid-pregnancy. The maximum volume is reached about the beginning of the last trimester and this level is then maintained until just before delivery when there is a slight drop. The increase in plasma volume ranges from 14 to 121 percent with an average of about 48 percent.[6] The total hemoglobin mass (Hb. in gm./100 cc x total blood vol.) increases, on the average, about 15 per cent, but this is not evident because of the proportionately greater increase in plasma volume.

The most accurate clinical measurement of the state of the blood is the hematocrit or packed cell volume. The least accurate is the red cell count, and the hemoglobin lies somewhere between. There has been a good deal of conjecture as to what should be considered the physiologic limits of these values during normal pregnancy. For example, Lund[7] found approximately 20% of 4,015 gravid women with hemoglobin values below 10 gm. If 11.0 gm. was used as the lower limit of normal, 50% were anemic. It should be noted that 90% of his patients were colored. Adair and Dieckmann[8] considered the physiologic limits between the twelfth and thirty sixth weeks to be a hemoglobin of 10.0 gms.%, an hematocrit of 33 volumes %, and an erythrocyte count of 3.36 million. They estimated that approximately 12% of all pregnant women were anemic. Bethell[9,10] at the University of Michigan established the lower limits of normal as 11.3 gm. (70%) of hemoglobin and 3,700,000 erythrocytes per cu. mm. Other investigators have accepted more rigid or more liberal values with resultant confusion as to what actually constitutes a pathological state.

At Lewis Memorial Maternity Hospital we have considered a hematocrit of 30 volumes per cent as the lower limit of normal during the second and third trimesters of pregnancy. The normal for non-pregnant women is between 37 and 44 per cent. During the last few weeks before delivery there is some hemoconcentration due to a decrease in the plasma volume, and a packed cell volume of 32 to 33 percent is considered the minimum at this time.

Hemoglobin values of 10.0 gm. in the 2nd or 3rd trimester and 10.5 in the last few weeks before delivery have been accepted as the lower limits of normal. The minimum normal red cell count is considered to be 3.5 million.

At Lewis Memorial Maternity Hospital during 1955, 33% of the patients had hemoglobin levels below 10 gm., whereas only 18.5% showed a packed cell volume below 30 per cent. In other words iron deficiency was more common than a decrease in the number of red blood cells.

A useful index of the degree of iron deficiency

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is the mean corpuscular hemoglobin concentration (MCHC):

$$\frac{\text{Hb. in gm./100 cc}}{\text{Hematocrit in Vol. \%}} \times 100 = \text{MCHC in \%}$$

Normally this varies between 32 and 35% regardless of hemodilution. The mean corpuscular hemoglobin is of less value clinically because of the greater error in counting the number of red cells:

$$\frac{\text{Gm. of Hb./L of bl.}}{\text{Rbc in millions}} = \text{MCH in micrograms (normal 27-32)}$$

Physiologic hemodilution during pregnancy should not be referred to as anemia. It should be emphasized that normal pregnancy does not produce anemia. Anemia is always an indication of an abnormal state.

## IRON DEFICIENCY ANEMIA

By far the most common anemia encountered during pregnancy is the iron deficiency anemia. In this condition the hemoglobin is usually lowered to a relatively greater extent than the red cell count and consequently the mean corpuscular hemoglobin concentration is below 30%. As a rule there is also a fall in the hematocrit below 30 volumes per cent. The red cells are characteristically small and the mean corpuscular volume is below 80. The cells frequently are irregular in size and shape and since they contain less hemoglobin than normal they are hypochromic. The bone marrow reveals a normoblastic erythropoiesis.

This type of anemia often exists prior to pregnancy and is simply discovered on routine examination during pregnancy, or is minimal prior to pregnancy and is exaggerated by the increased demand for iron during pregnancy.

In order to treat hypochromic anemia intelligently the cause of the iron deficiency should be sought in each patient. To aid such evaluation it might be well to list in the order of their frequency the common causes of iron deficiency in women of child-bearing age:

(1) Chronic hemorrhage is probably the most common cause. The most likely source of such bleeding is excessive menstrual flow. The average loss of blood during normal menstruation has been estimated at 30 to 50 cc. containing between 12 to 25 mg. of iron. If excessive flow recurs at monthly intervals the loss of iron may be greater than the amount absorbed from the diet and iron deficiency anemia will result. Chronic blood loss may also occur as the result of bleeding hemorrhoids, bleeding gums, peptic ulceration, or chronic parasitism. In the last year or so, with the influx of Puerto Rican and Mexican patients into our pre-natal clinic, we have noted a striking increase in the incidence of ascaris, hookworm and other commonly encountered parasites of warm climates. Thus it is rewarding in the routine investigation of the cause of iron deficiency anemia to examine warm stools for ova and parasites and to analyze stools for occult blood after three days' restriction of meat and green vegetables.

(2) Insufficient dietary intake of iron is the second most frequent cause of iron deficiency anemia in our experience. This is particularly noted in indigent patients and in patients who have an inadequate knowledge of what constitutes a normal diet and is quite prevalent in the colored population of our clinic. Is should be emphasized, however, that this factor is not limited to poorly informed and indigent groups and is all too frequently encountered in economically better patients as a result of diet fads and erratic tastes. Anorexia, persistent heartburn and hyperemesis gravidarum may also contribute to the incidence of dietary insufficiency of iron.

Dietary studies have shown that the greatest incidence of iron deficiency anemia is noted in those who ingest less than 8 mg. of food iron daily.[10] The average well-balanced diet in the U.S. contains 10-12 mg. of iron daily. Such a diet would consist of 1 egg, 1 serving of red meat, 4 slices of whole wheat or "fortified" bread and 2 servings of vegetables. Actually only about 0.5 to 1.5 mg. of this daily intake of iron is absorbed.[11] The rate of absorption is inconstant and subject to cyclic variations depending on the needs of the body.[12,13,14]

(3) Insufficient absorption or utilization of iron as a result of hypochlorhydria is seldom a cause of anemia during pregnancy. Balfour et al.[15] have shown by radioisotope studies that the rate of iron absorption from the G. I. tract is increased 2 to 10 times during pregnancy as compared to the non-pregnant state. Occasionally, if infection such as recurrent pyelonephritis exists, there may be some interference with the utilization of absorbed iron.

(4) Increased demand for iron undoubtedly does occur during pregnancy and lactation but it is difficult with presently available means of investigation to assess the importance of this factor. Fetal iron requirement seldom exceed 250 to 300 mg. When the total content and distribution of iron in the body is analyzed it would seem that this fetal requirement could easily be met without undue strain in the normal individual. The total body content of iron has been estimated between 4.5 to 5.0 gms.[16,17] Fifty-five per cent of this is present in the circulating hemoglobin, 10% in the muscle hemoglobin, 30-35% in storage (of which 66% is in the liver, spleen and marrow), and 1% in the plasma.

(5) "Idiopathic" hypochromic anemia is a wastebasket for those cases in which no apparent cause for an iron deficit is found. Thorough search will in almost all instances reveal the cause of the deficit. It would be better, therefore, to designate this group: "iron deficiency anemia, etiology undetermined."

The treatment of iron deficiency anemia is simple. If there is persistent blood loss, appropriate measures to correct the condition responsible for the bleeding must, of course, be employed. The amount of iron in the diet is increased as much as possible and one of the iron salts is administered in tablet or capsule form after meals. The ferrous salts are usually better tolerated than the ferric preparations.

It should be emphasized that none of the trace elements so frequently advocated appreciably enhance the effect of iron.[17] As Sturgis[18] has aptly pointed out: "iron and iron alone is indicated in an iron deficiency anemia, and the addition of liver, stomach extract, copper, or any other form of alleged adjuvant is of no practical value." Molybdenum and cobalt may be added to this list. These adjuvants do not increase the therapeutic response sufficiently to justify the increase in the cost of therapy.

Gastrointestinal intolerance to iron is sometimes encountered even when the ferrous salts are used. Such intolerance can usually be overcome by administering the tablets immediately after meals and by starting with a single tablet daily and adding one tablet every few days until the desired dose is attained.

Iron preparations are now commercially available for intravenous therapy, but their use should be limited to very special circumstances. It should be emphasized that iron is a "one-way" metal, since very little absorbed iron is excreted. The maximal daily excretion is usually about 1.0 mg. via the stool (bile). A very small amount may be excreted in the urine after intravenous administration of iron oxide.[19] Any excess of iron which gains access to the body, is stored mainly in the liver until that organ becomes saturated and then in the spleen, bone marrow and kidneys. The indiscriminate use of iron, may therefore, produce hemosiderosis and possibly even hemochromatosis. Several serious and even fatal reactions to intravenous iron have been reported.[20,21] For these reasons intravenous iron should be used with caution and only in amounts sufficient to correct the existing deficiency. In calculating the total amount to be injected, 25 mg. of metallic iron is given for each 1% deficit in hemoglobin. As a rule, no more than 100 mg. should be injected in one day. The peak of the reticulocyte response following injection of iron occurs between the 8th and 12th days and the degree of reticulocytosis depends upon the severity of the anemia. Thus the response is similar to that obtained when either vitamin B-12 or liver extract is administered in pernicious anemia.

The only definite indication for the intravenous administration of iron is absolute intolerance to oral iron therapy. Its use may sometimes be justified when iron deficiency anemia is discovered near term. However, in this latter circumstance, it should be remembered, that an appreciable clinical effect may result from oral iron therapy within a two to three week period.

The use of blood transfusions in iron deficiency anemia is seldom indicated. It should be remembered that a transfusion of 500 cc. of whole blood will deliver about 250 mg. of iron. This is a sizable intravenous dose and if repeated unnecessarily may have the same undesirable effects as the intravenous administration of iron.

Transfusion is often considered necessary when anemia is discovered during the last few weeks of pregnancy. Lund[7] has estimated that two to three weeks of oral iron therapy will actually produce a response equivalent to the transfusion of 1000 cc. of whole blood and six weeks of such therapy will, at one fortieth of

the cost, give the same result as 2000 cc. of blood!

If there is severe anemia at term, transfusion is indicated. The hemoglobin should be at least 9 mg. in order to avoid dangerous depletion by blood loss during normal or operative delivery.

The potential hazards of incompatibility, febrile reactions, allergic reactions, hepatitis, and hemosiderosis should discourage indiscriminate employment of transfusions.

## MACROCYTIC ANEMIA OF PREGNANCY

Some cases of iron deficiency anemia which fail to respond to iron therapy have been noted to have a peripheral macrocytosis.[22] The incidence of this type of anemia has been estimated by various authors between 10 and 20 per cent of all true anemias of pregnancy. There appears to be a close correlation between the occurrence of this anemia and a low intake of protein, especially protein derived from animal sources. The bone marrow is normoblastic. Increasing the daily intake of protein (particularly meat) to 100 grams or more leads to the prompt correction of this anemia even if treatment is not begun until the last trimester of gestation.

## MEGALOBLASTIC ANEMIA OF PREGNANCY

It may well be that the so-called "pernicious anemia of pregnancy and puerperium" is simply a more severe and progressive stage of the milder macrocytic anemia just described. However, pernicious anemia of pregnancy is characterized by a typical megaloblastic marrow not unlike that seen in true Addisonian anemia and while inadequate protein intake is common, the primary deficiency seems to be in the intake or utilization of folic acid.

This type of anemia may occur at any time in pregnancy, but is seen most frequently in the last trimester or in the early puerperium. It usually develops rapidly within a period of two weeks or less.

A sore tongue or some other mouth lesion may be the first sign of illness or may develop later in the course of the disease. Vomiting and diarrhea occur in 40 to 50 per cent of the cases.[23] The skin becomes pale and waxy. Retinal hemorrhages are frequent. Slight to massive dependent edema is common. Fever without evidence of infection may occur.[24]

The diagnosis of megaloblastic anemia of pregnancy is made by finding in the bone marrow the typical arrest of maturation of red cells in the megaloblastic stage. The anemia is usually severe. Peripheral blood smears often reveal large erythrocytes with an increased amount of hemoglobin. However, the peripheral smear may show a normocytic picture and may even, when there is superimposed iron deficiency, display a microcytosis. The leucocyte count may reveal either a moderate leucocytosis or a leucopenia. Large, multinucleated polymorphonuclear cells are seen. The reticulocyte count is normal or low in untreated patients. The serum bilirubin, urinary urobilinogen, and fragility tests are all normal.

This anemia has been termed "pernicious anemia of pregnancy" because some features (the peripheral hyperchromic, macrocytic pattern and the megaloblastic bone marrow) are similar to true Addisonian pernicious anemia. However, histamine achlorhydria, smooth tongue and splenomegaly are uncommon. Neurologic manifestations are characteristically absent. Spontaneous remission is the rule after delivery, whereas Addisonian pernicious anemia requires continuous therapy. Megaloblastic anemia of pregnancy may or may not recur with subsequent pregnancies. To date there has been no evidence that these women have a predisposition to develop Addisonian pernicious anemia in later life.

The outlook for the fetus in megaloblastic anemia of pregnancy is good. The incidence of stillbirth or congenital abnormalities is not increased. Premature delivery, however, has been noted in a significant number of patients.

The disease appears to be much more frequently encountered in the British Isles[23] and in some parts of Asia than in the United States. We have had only four cases at Lewis Memorial Maternity Hospital in the last 12 years.

Refined and concentrated liver extract is of no value in the therapy of this anemia. Crude liver extracts in large doses parenterally and oral preparations of liver have been moderately effective. Their effectiveness is thought to be due to their folic acid content. Most investigators have likewise found Vitamin B-12 completely ineffective in this anemia. However, Patel and Kocher[25] in Bombay, India reported good results with B-12 in 5 cases. Whether the disease is due to a dietary deficiency of folic acid or to a defect in utilization of folic acid, folic acid

either orally or parenterally in 2.5 to 5.0 mg. doses will cure the anemia. A reticulocyte response proportionate to the degree of anemia will occur in 7 to 10 days after initiation of therapy. Therapy should be continued throughout the remainder of the pregnancy, or if it occurs during the puerperium, until complete remission has resulted.

Spies[26] has recommended the routine administration of 2 mg. of folic acid daily during the latter months of pregnancy to prevent the occurrence of this type of anemia. Since the condition is so rarely encountered and since it responds so readily to therapy, prophylactic measures of this sort hardly seem indicated.

Rarely, true Addisonian pernicious anemia may have its inception during pregnancy. It is always associated with a histamine achlorhydria and responds with an incomplete remission to folic acid therapy alone.

## HYPOPLASTIC ANEMIA OF PREGNANCY

This anemia described by Holly[29] requires transfusion therapy. Fortunately spontaneous remission frequently occurs after delivery. We have never encountered a patient with this type of anemia.

## PRIMARY PRE-EXISTENT ANEMIAS COMPLICATED BY PREGNANCY

Pregnancy is rarely encountered in patients with aplastic anemia. When this combination does occur one can only resort to repeated transfusions in the hope that one will obtain a viable child.

Sicklemia occurs in 8 to 14 per cent of the negro population and can be expected in the same proportion of gravid negro women. No ill effects occur during pregnancy as a result of this trait. Sickle cell anemia occurs in approximately 0.2 per cent of patients with the sickle cell trait. The occurrence of pregnancy in a patient with a severe sickle cell anemia usually has serious consequences. Toxemia, premature labor, morbidity and mortality are all increased. Fortunately pregnancy occurs infrequently in anemia of this type, apparently because of decreased fertility. There are only twenty-nine cases reported in the literature.[27] We have had only one case at Lewis Memorial Maternity Hospital in spite of a high percentage of colored patients.

Pregnancy has been reported in association with other primary anemias and hematologic disorders. For the most part the problem in such cases is that of the underlying disease.

## POST-PARTUM ANEMIAS

Wolff[28] states than anemia encountered during the puerperium is usually due to one of the following factors: (1) Pre-existing anemia of pregnancy which has not been recognized during the ante-partum period because of failure to get routine blood counts. (2) Excessive blood loss at the time of delivery. This blood loss is frequently underestimated. (3) Puerperal sepsis and other septic states which temporarily suppress bone marrow function or even cause toxic destruction of red cells. (4) Toxic effect of drugs. Antibiotics and sulfa compounds particularly may suppress the marrow.

It is well to evaluate the blood picture at about the 3rd post-partum day and just prior to discharge. If anemia is present, appropriate therapy should be prescribed.

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## Two hundred epileptics

Anticonvulsant medication was given to a group of 200 children having severe behavior disorders with the common characteristic of periodic, paroxysmal outbursts of impulsive behavior which seemed imbedded in a matrix of generally bad behavior. No frank convulsive seizures were noted in any case but the electroencephalograms of all these children were abnormal and included features found among patients with generalized seizures. Results show improvement in behavior in 70 per cent of the cases treated with anticonvulsant medication. Twenty-five per cent of the patients remained the same, and in five per cent worse behavior was reported following therapy. Electroencephalograms improved in 50 per cent and Rorschach protocols in 55 per cent of the patients. The addition of an organic Rorschach initially in the majority of cases showing improvement, it is believed, provides evidence of a nonpsychogenic etiology. The nature of behavior change consisted in a reduction of excessive reaction and less intense response. The presence of four positive factors — paroxysmal behavior, abnormal electroencephalogram, organic Rorschach, and definite improvement with the anticonvulsant drug, Dilantin — warrants the inclusion of this group of children in the diagnostic category of epileptic equivalents. It seems, however, that a distinction should be made between epileptic equivalent and psychomotor epilepsy, and evidence in this study points away from epileptic equivalent and psychomotor epilepsy being the same. Electroencephalographic findings are more in line with what is often seen in grand mal and seem more in keeping with a frontal lobe origin. Finally, it is believed that thinking in epilepsy should be reoriented to the possibility that the phenomenon of epileptic equivalent is not associated predominantly with adulthood but is more common in childhood than is generally realized. *Frederic T. Zimmerman, M.D. Explosive Behavior Anomalies in Children on an Epileptic Basis. New York J. Med. Aug.* 15, 1956.

## The symptoms of alcoholism

The range of I. Q. scores for alcoholics is the same as for nonalcoholics. The alcoholic tends to be suspicious and sensitive, unable to tolerate pressure. He is worried, anxious, easily depressed, and is likely to change jobs often. Another characteristic of the mature alcoholic is social isolation. He thinks that no one understands him, especially those who are close to him. He generally has few real friends. The alcoholic's motive for drinking is to escape the reality of life and to create a world of fantasy — unreality. He finds himself drunk regularly. He needs that morning drink to get organized. Going on benders usually marks the beginning of the chronic phase. A bender is a period of a day or more in which a person drinks blindly, helplessly, with just one purpose — to get drunk. Possible impairment of his character and personality traits may occur, as for instance:

Initiative - loss of ability to start new activities.

Trustworthiness - loss of confidence in one's sense of responsibility in work and social relationships.

Personal appearance - resulting in poor grooming and slovenliness in dress.

Perception and memory disappear as restraint and self-control are lessened.

The field of observation is narrowed, muscular co-ordination is weakened, and clumsiness takes the place of precision, often resulting in mishaps. Alcohol does not cause organic damage of any cells in the brain or the rest of the body; it affects only the functions of the cells as they are controlled by the central nervous system. The alcoholic is sick, for excessive use of alcohol may bring about personality deterioration and mental defects, loss of physical vigor, and nutritional deficiency. *Paul S. Rahneff. Editorial. Minnesota Med. July* 1956.

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With adequate present-day methods of treatment of tuberculosis plus good obstetric care, pregnancy should rarely be accompanied by unfavorable progression of disease. Loren M. Rosenbach, M.D., Columbus R. Gangemi, M.D., J.A.M.A., July, 1956.

## Emotional upsets and colitis

I usually tell my patients in the first interview that colitis is caused by emotional upsets, and illustrate my meaning from previous case histories. Many patients will agree at once and say they have long known the effect of nervous tension on their disease. "It always goes straight to my stomach, Doctor," or "I felt everything tighten up inside." Others will not at first accept the psychosomatic explanation. It is important to explain that the emotional factor may appear to be quite trivial. Though a big stress, such as mother's illness or death, often is a trigger, more often it is because a sister-in-law has not spoken for six months, or because the husband prefers the races to taking his wife to Devon or because the patient dreads Sunday night, when she has to play dominoes with her mother-in-law and is ragged for her inadequacy at the game. To the outsider these things are trivial in the extreme but not to colitis patients with the personality peculiar to them. Until the doctor, the patients, and their relations realize that such apparently unimportant factors may be vital and paramount, the handling of these cases will be slow and unsatisfactory. *J. W. Paulley, M.D. Psychotherapy in Ulcerative Colitis. Lancet,* Aug. 4, 1956.

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## Oh boy

A prenatal patient came to my office and I announced to her that the State Department of Health has polio vaccine available for all children under 19 and for pregnant women, regardless of age. "Would you like to have your shot today?" She said, "Oh, no. We have polio insurance. We paid $10.00 for it and it will pay $5,000 if I get polio so I'd be a fool to take the shot." *A. P. Peeke, M.D. The Role of the General Practitioner in Rural Health. South Dakota J. Med. & Pharm. July* 1956.

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The ancient art and the burgeoning science of medicine know no national or racial distinctions. Medicine, like art and music, speaks with a human tongue, and its knowledge and techniques are dedicated to all mankind. Ed. World Med. J., May, 1956.

# CASE REPORTS



# The Differentiation of Skeletal From Visceral Pain in the Thorax

**Chester B. Thrift, M.D., and George Gumerman, M.D., Chicago**

PHYSICIANS usually think of chest pain in terms of thoracic contents. This tendency is especially marked among the laity, currently very heart-conscious because of the recent articles in the press. Even among physicians, pain felt in the thorax, but due to disease outside this structure, in the neck, abdomen or central nervous system, does not so frequently come to mind. Changes in the chest wall, the skeleton, skeletal attachments, and even in the integument are of especial interest to us as rheumatologists.

The thorax is innervated by the lower cervical roots. Nerves originating in the thoracic portion of the spinal cord supply motor and sensory innervation to the upper abdomen.

The thoracic viscera, the lungs and heart, with their visceral coverings, are insensitive[1]; not so, the parietal layers of the pericardium and pleura. Sudden changes in volume by stretching, spasm, or ischemia, such as that of coronary insufficiency or spasm of pulmonary arteries, can be exquisitely expressive. Dilatation or marked contraction of the esophagus is felt as pain, probably explaining the globus sensation. The sensation of heartburn is recognized as esophagitis. Regurgitation of gastric contents into the esophagus is a part of diaphragmatic herniation.

Severe pain may exist with little or no representation or detectable changes in structure. On the other hand, the finding of extensive intrathoracic pathology, such as huge effusions, abscesses, pulmonary or cardiac disease, is explainable through the lack of pain receptors in the visceral coverings and by the high pain threshold of some patients.

If discomfort is suspected of being visceral or skeletal, localizing evidence should be sought. Findings, even obvious, are to be carefully scrutinized. Vertebral spurs do not exclude the possibility of dissecting aneurysm. The symptom of pain is caused by pressure on the posterior nerve roots. The history of the patient is, by far, the best guide.[2] An important feature in the history is not the location, quality, or intensity of the pain, but the relation of the pain to such body functions as breathing, coughing or change of position.

## DIFFERENTIAL DIAGNOSIS

1. SOFT TISSUE PAIN
   - Myopathy
     - Infectious (trichinosis)
     - Traumatic
   - Neuropathy
     - Herpes zoster
     - Tabes dorsalis
     - Diabetes

*From the Arthritis Clinic of Cook County Hospital*

Subvitaminosis B
Parphyia
Other Causes
Polyarteritis
Dermatomyositis
Periarthritis of shoulder

2. VERTEBRAL OR INTRASPINAL PATHOLOGY WITH RADICULAR SYMPTOMS
Tuberculosis
Osteoporosis
Metastatic lesions
Cord tumor
Protruded intervertebral disk
Dengenerative arthritis [Vertebral Osteophytosis]
Strümpell-Marie arthritis
Epidural abscess
Metastatic bone disease other than spine
Osteomyelitis of spine
Myeloma of thoracic vertebrae
Epiphysitis [Scheuermann's Disease]
Hodgkin's Disease

3. CARDIAC
Coronary insufficiency (angina pectoris)
Coronary thrombosis
Pericarditis
Valvular lesions
Aortic stenosis
Mitral stenosis

4. PLEURAL
Pleuritis
Neoplasm of breast and lung
Pneumothorax

5. AORTIC
Aneurysm
Rupture
Aortitis

6. PULMONARY EMBOLISM

7. TIETZE'S SYNDROME

8. OTHER CAUSES
Painful callus of rib
Sarcoidosis

## PATIENT PRESENTATION

This colored patient, aged 62, was born in Texas. Except for ordinary childhood diseases, he was perfectly well until 1918. In the army he suffered pains in his knees when sleeping on the ground. Later he worked for seven years as a laborer with his feet constantly wet.

In 1925, he complained of pain in the arches of his feet. He attended the Veterans Administration where his feet were taped. A private doctor treated him for four years. With corrective shoes, the skeletal complaints disappeared for thirteen years.

In 1938, on lifting rocks, he strained the muscles in the low back, for which he was hospitalized at Fort Sheridan for four weeks. He was re-hospitalized for two months in 1939 because of back pains. X-Rays were made. The diagnosis was strained muscle. In 1940, at the age of 40, he was given a medical discharge from the army because of pain in his back.

Between 1940 and 1949 he was re-hospitalized three times in a veterans' hospital for hypertension. He was discharged after the blood pressure was reduced.

In 1952, he quit his job because of pains in the chest. He was re-admitted to a veterans' hospital. Twenty-five electro-cardiograms and other tests were performed. He was discharged after six months with a diagnosis of neuralgia of the chest and spine. In 1953, a cholecystectomy was performed because of gallstones.

He was admitted to Cook County Hospital, September 7, 1952, at the age of 58, because of pain in the chest which persisted for nine hours. It was sharp, stabbing, and located under the left nipple. He was given oxygen for 24 hours. He had numbness in the radial and lateral third finger of the left hand, and pain in the small of the back. There was a sharp pain in the left fourth intercastal space, brought on by moving or talking. His blood pressure was 110/70, pulse 76, respirations 16, temperature 98.6, W.B.C. 13,600 with polymorpho-nuclears 76%. Two electrocardiograms showed left heart strain.

His second and third admissions to the Cook County Hospital in 1953 were for hematuria following transurethral resection of the prostate for benign prostatic hypertrophy. On those admissions he had recurrent episodes of chest pain unrelated to exertion.

From September 1952 to September 1953, he was given digitalis and phenobarbital as an outpatient.

He was admitted for the fourth time because of epistaxis lasting twenty-four hours. His blood pressure was 148/98; his pulse 88. The left little finger and the lateral half of the left index finger were anesthetic. He had bilateral chest

pain, not aggravated by twisting or bending. This pain was worse in the morning, and lessened as the day progressed. Nitroglycerine caused anxiety and headaches without affecting the pain. APC tablets lessened the pain.

In January 1955, a diagnosis of "thoracic arthritis" was made in the cardiac clinic of Cook County Hospital. He was treated without relief with digitalis, belladonna, phenobarbital, and nitroglycerine.

In the Arthritis Clinic of Cook County Hospital, in April 1955, at the age of 61, he was described as a well-nourished colored man of athletic build. He weighed 212 pounds. He never smoked, used to drink beer occasionally, and had no history of lues or anti-luetic treatment. There were no children by two wives. The first wife had a miscarriage at two months. He had gonorrhoea at 18 years of age.

Anteriorly the chest showed no deformity or scars. It was symmetrical and barrel-shaped. The respiratory excursions were free and easy. The breasts were somewhat pendulous. The pulsations of carotid and brachial arteries on both sides were visible.

The left heart border was at the mid-clavicular line. Right heart border was at the right edge of the sternum. Upper heart border at the third rib in the left para-sternal line. The first tone at the apex was replaced by a blowing murmur, limited to the apex. A rough systolic murmur in the aortic area was not transmitted. The A2 was accentuated and metallic. Lungs were clear. No ascites or edema. Liver or spleen were not felt.

The left second costosternal joint was swollen, 4 cm. in diameter by 1 cm. in thickness. It was slightly tender but not red or hot.

There was a moderate kyphosis and a slight right lateral scoliosis of the lower thoracic vertebrae. The lumbar area showed continuation of the scoliosis. A scar 7 cm. in length opposite the last rib was due to the removal of a lipoma. The lumbo-sacral junction and the ilio-sacral joints were tender. Murphy's test was negative on both sides. There was no limitation of either active or passive motions of the spine in any direction.

There was no arthropathy of the extremities.

The left little finger and the lateral half of the left index finger were hypalgesic when tested with a pin. There was no evidence of swelling or limitation of motion of the affected digits.

X-rays of the cervical and thoracic spine showed moderate lipping of the vertebrae. An antero-posterior view of the chest showed no abnormalities of the heart, lungs, or visible aorta. A lateral view of the chest showed increase in the soft-tissue density at the left second costosternal joint, with a marked subcostal thickening.[8] Barium swallow studies of the esophagus were normal

On cardiac fluoroscopy, the aorta was found to be tortuous and calcified. There was fusiform dilatation of its ascending segment. The left ventricle was globular, but not significantly enlarged. This was confirmed by routine radiographs and interpreted as arteriosclerotic configuration, expected with advancing age. Likewise, degenerative changes in the dorsal spine are not unusual for the patient's stated age.

The blood pressure was 150/84, pulse 84, respirations 18. On Master's 2-step test, electrocardiograms made before and after exercise were negative.

There was nerve deafness on the left. Urologic study disclosed a stricture of the urethra.

The laboratory showed a uric acid of 7.5 mg./100 c.c., B.M.R. −1. Kahn negative, sedimentation rate 6 mm./hr., R.B.C. 5.68, Hb. 90%, color index .79, W.B.C. 6,360. Electrophoretic pattern indicated a normal distribution of proteins (analyzed by N. Paul Carstens of the clinic staff). N.P.N. 38 mg./100 c.c. Acid phosphatase 0.2 mg./100 c.c. Bodansky units. Bence Jones protein negative. Phosphorus 5.0 mg./100 c.c.

Although not relieved by lactose tablets given as an oral placebo, he experienced less pain for periods of three days following each subcutaneous injection of 1 cc. of normal saline in the hip.

## SUMMARY

A colored male of 62 years had intermittent chest pain for four years. Because of his age, he is a candidate for vascular disease, particularly of the coronary arteries. Several aspects of his chest pain suggest coronary insufficiency. X-ray studies show the degree of degenerative arthritis in his spine characteristic of his age and previous work habits. Continuous observation and repeated examinations make it likely that at least a sizable part of the chest pain is due to degenerative changes of the spine.

Further evidence of clinical joint disease is

seen in the left second costosternal joint. This finding is interpretable as Tietze's disease.[2,3,4,5,6] This condition is not an uncommon cause of chest pain. It may be defined as a painful, benign, non-suppurative swelling of the costochondral or sternoclavicular junction. Sokoloff and Gleason[7] concluded that "the sterno clavicular joint is affected by various types of rheumatic disorder more frequently than is recognized clinically".

Lindblom[8] in 1944 made a study of the anterior ends of the ribs seen on the tangential films. He demonstrated in twelve cases of osteochondritis a noticeable swelling of the subcostal soft tissues. Our patient showed this phenomenon. A complete study of skeletal and visceral pain in the thorax should include a tangential film of the chest wall.

Our patient presented historical and physical evidence of intrathoracic (cardiac) and skeletal disease. The pains in his chest varied with their origin. Patients with thoracic pain require careful analysis of the history, and all available physical and laboratory evidence to determine whether the present illness is in the thoracic cage or its contents. The differentiation is especially difficult in the face of evidence compatible with both skeletal and parenchymatous disease.


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## Drug therapy

Around the turn of the century, Osler and other medical leaders were seriously concerned about the profusion of what seemed to them to be either highly questionable or useless preparations. Many of these multiple-ingredient preparations had been handed down from generation to generation of physicians without any attempt to really determine their merits. As a result, hundreds of useless concoctions were discarded, and a healthy skeptical attitude developed concerning drug therapy. Fortunately, this prepared the way for really worth while advances. The Council on Pharmacy and Chemistry was established and a much more intelligent and conservative approach was developed concerning all drug therapy. As a result of these developments, and in the light of present day concepts, it is apparent that around 1900 only about one really new worth while medical substance had been developed in 25 years. This is in sharp contrast to what has been happening in recent times. By 1940 about 95 new pharmaceutical specialties were introduced. By 1954, this had risen to 550, and there is no indication that there is any slowing down in the pace. Approximately 90 per cent of all prescriptions call for drugs developed in the past 15 years. Among this profusion there are some really worth while drugs but unfortunately these are not always afforded the recognition they deserve because of the confusion created by the many. *Dale G. Friend, M.D. and George A. McLemore, Jr., M.D. Some Abuses of Drugs in Therapy. New England J. Med. June* 28, 1956.

# EDITORIALS

## Illinois State Medical Society signs 'medicare' contract

Officials of the Illinois State Medical Society and the Illinois Medical Service have signed a contract with the Department of Defense to provide medical care for dependents of personnel in the uniformed services.

The program, established by Congress under Public Law 569, went into effect on December 7. It is designed to make greater use of civilian medical and hospital facilities in the care of military dependents.

As decided by the Council of the Illinois State Medical Society, Illinois Medical Service will act as fiscal agent for the state medical society in its dealings with the Army, which is the agent for all uniformed services. Payments to Illinois physicians for medical care under this program will be made by the Illinois Medical Service, which in turn will be reimbursed by the Defense Department.

In two days of intensive negotiations with officials of the Army Surgeon General's office in Washington last month, representatives of the state medical society agreed on a fee schedule covering approximately 1,500 medical and surgical procedures. Detailed information on the fee table will be made available in the near future.

It was recommended at the special meeting of the House of Delegates in August that charges for various medical services do not exceed the usual fees in any community.

The men who represented the Illinois State Medical Society in the Washington negotiations on November 2 and 3 were Drs. F. Lee Stone, society president; Lester S. Reavley, president-elect; H. Close Hesseltine, Council chairman; Percy E. Hopkins, chairman of the Committee on Medical Service and Public Relations; Harold M. Camp, secretary-treasurer, and Mr. John W. Neal, general counsel.

"Medicare" is being administered by a former Illinoisan, Major Gen. Paul I. Robinson, executive director of the Office for Dependent Medical Care.

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## New drugs

Eli Lilly and Company deserves to be congratulated on the way it handled carbutamide (BZ-55). The firm was under tremendous pressure by manufacturing chemists to place this oral, antidiabetic, sulfa-like drug on the market. But Lilly resisted, preferring to continue using it experimentally. At one time, more than 3,000 physicians were testing it on 20,000 patients.

This judgment was sound because many months of experimentation on a large series of patients were needed to determine that the incidence of side effects was approximately 9 per cent. When several deaths were reported, the widespread testing was called off.

During the past 10 years, many new products have been introduced. Some received a minimal clinical trial and one in particular was announced to the public before it was presented to the medical profession. Lilly's method is most

commendable and should serve in the future as a model. There is every indication that the Upjohn Company will pursue a similar course in testing tolbutamide (Orinase, U-2043). This compound has a similar chemical formula except for the sulfa radical.

Physicians trying experimental drugs play an important role in determining their safety. This responsibility should not be taken too lightly. Physicians who participate in these clinical trials will be asked to give evidence showing that the experimental drugs were used and that all the necessary laboratory procedures were performed as reported.

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## Advisory board of necropsy service to coroners

Governor Stratton has appointed seven of the nine members called for in legislation passed last year by the General Assembly as an Advisory Board of Necropsy Service to Coroners. As required by the act, appointments were made for one, two and three years. Regular appointments hereafter will be for three year terms.

Appointed for one year were Dr. Jacob E. Reisch, 500 South Fifth Street, Springfield and Dr. Joseph Hallett, coroner, McLean County, Bloomington. Appointed for two years were Dr. David O. Holman, pathologist, St. John's Hospital, Springfield, and Clark Davis, coroner, Grundy County, Morris.

Three year appointments were Dr. Edwin F. Hirsch, pathologist, St. Luke's Hospital, Chicago; Don Wikoff, coroner, Champaign County, Urbana; and Bernard McDevitt, Chicago, attorney and professor of medical law at Stritch School of Medicine, Loyola University.

In accordance with the law, three of the board members are licensed physicians and surgeons, three are elected coroners and three possess special interests and abilities in the field of legal medicine.

Duties of the board include assistance to local coroners in improving services, and study of ways and means to modernize state laws concerned with the investigation of deaths from other than natural causes.

Legislation creating the board was endorsed by the Illinois State Medical Society and the Illinois Coroners' Association.

## Uniform chemical labeling law proposed

It has been estimated that there are no less than 250,000 different trade name chemical products that may be used in the home, on the farm or in industry. Unfortunately there has been no complete cataloguing of these products so that proper warninges as to their use can be issued. At least 3,200 deaths have occurred on the farms of America from misuse of chemicals. Many other deaths have resulted from their misuse in the home, in industry and elsewhere.

The American Medical Association's Board of Trustees has authorized a first step toward protecting the public from potentially dangerous household and commercial chemicals. The Board authorized the A. M. A. committee on toxicology to draft a recommended "model" law on labeling of many possibly harmful chemicals not now so regulated.

It would serve as a guide for writing regulations which require labels to show such information as to the product's contents, its possible dangers, directions for safe use, and first aid instructions. Products involved include auto care and repair materials, paints and paint removers, putty, soldering fluids, household cleansers and polishers, heating and cooking fuels, laundering items, art supplies, and toys containing chemicals.

In addition to these are the many chemicals used on the farm, many of which do not have labels telling of their toxicity, and possible harms which may result from their misuse.

Legislation is needed to protect the public against the dangers which may result from misuse of chemical products.

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## Illinois Congress on Maternal Care

The first Illinois Congress on Maternal Care sponsored by the recently formed Illinois Committee on Maternal Welfare, will be held at the Hotel St. Nicholas, Springfield, February 13-14, 1957.

The Illinois Committee on Maternal Welfare is a pilot program of the American Committee on Maternal Welfare designed to invite the most active participation of professions concerned with achieving optimum maternal and newborn

care in Illinois. "Illinois Reviews Its Maternity Care" has been chosen for the theme of this meeting in February.

The program has been planned to bring together members of the various professions for discussion and ultimate solution of mutual problems. These include general practitioners, obstetricians, pediatricians and anesthesiologists, nurse anesthetists, obstetric, pediatric and public health nurses, hospital administrators, medical social work personnel, officers of accredited public health agencies, nutritionists, and others.

This first state Congress will offer a comprehensive program of panel discussions, breakfast conferences and round tables to enable the maximum number of persons to participate in small group discussions. A highlight of the Congress will be the banquet February 13, featuring a speaker of national renown.

The overall program is being developed by a planning committee under the chairmanship of Dr. Martin W. Green of River Forest, composed of key representatives from the fields mentioned above, each of whom will head a program subcommittee in his particular field.

At the last annual meeting of the Illinois State Medical Society, the Section on Obstetrics and Gynecology endorsed the Illinois Committee on Maternal Welfare and voted to become a member organization.

Physicians desiring additional information and official program for the first Illinois Congress on Maternal Care, may receive same by writing to Hubert L. Allen, M.D., Chairman, Illinois Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Illinois.

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## Psychiatry program approved

It was recently announced by Governor William G. Stratton that full approval of the Illinois Department of Public Welfare program for training of residents in psychiatry has been received from the American Board of Psychiatry and Neurology and the American Medical Association.

According to Dr. Otto L. Bettag, director, this approval means that physicians completing the training program qualify for examination by the American Board of Psychiatry and Neurology for certification as specialists.

Developed by the department to combat a shortage of psychiatric personnel, the program is under the leadership of Dr. Percival Bailey, director of the Illinois State Psychopathic Institute. Twenty-five physicians are now enrolled. Anticipated enrolment will be 50 by next year and 100 when the Psychiatric Institute State Hospital is completed in approximately two years.

The residency in psychiatry training program links the educational resources of the state welfare department with those of other public agencies and private hospitals. While varying widely according to the abilities and interests of individual students, the program aims at providing experience with psychiatric problems on both the in-patient and out-patient basis, with adequate opportunities in all types of diagnosis and treatment.

Depending on the physician's previous accredited training and experience, the program varies from one to five years. The basic program is a five-year plan providing three years of training plus two years of clinical service in state mental hospitals. Cooperating in the program are Chicago, Elgin and Galesburg State Hospitals, the Institute for Juvenile Research and the Mental Health Centers, all facilities of the Illinois Department of Public Welfare, the Municipal Court of Chicago, University of Illinois department of neurology and psychiatry, Michael Reese Hospital and the Northwestern University hospitals.

The general requirements of the Council on Medical Education and Hospitals of the American Medical Association apply to all applicants for residency training. Vacation time and sick benefits will be provided, and residents in training become eligible for benefits and protections of the state Civil Service law after one year of service.

While in the training program residents in psychiatry receive a salary of from $300 to $640 per month. Career opportunities under the Illinois Department of Public Welfare are available for residents completing the program.

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According to TB Medical News, "alcoholism and tuberculosis mix all too easily, with tragic results for the individual and the community."

## Essay contest on the subject of animal experimentation

For the third time in four years, the Illinois Society for Medical Research is sponsoring an essay contest in Illinois high schools on the subject of animal experimentation. This year's contest is co-sponsored by the Illinois State Medical Society, the Illinois State Dental Society, the Institute of Medicine of Chicago, and the Illinois State Academy of Science.

The title of the 1956-57 essay contest is "The Value of Animal Experimentation." The contest was announced to high schools throughout the state, both public and private, via a circular letter sent late in September. As the circular letter announced, the purpose of the contest is twofold: first, to interest students in possible careers in medical and biological research; and second, to familiarize students with the humane methods whereby animal experimentation is performed, as well as its humane goals, thus undercutting the insidious picture of animal experimentation created by antivivisection propaganda.

The closing date for entries in this contest is March 15, 1957. The essays will then be evaluated by a distinguished panel of judges. Past judges for this contest have been: the late Dr. A. J. Carlson; Dr. Lester R. Dragstedt, President of the National Society for Medical Research; Dr. Willis Potts, then President of the Institute of Medicine of Chicago; Dr. Leland Shanor, then President of the Illinois State Academy of Science; Dr. LeRoy H. Sloan, Vice-Chairman of the Board of Directors of the Institute of Medicine of Chicago; and Dr. Austin Smith, Editor of the *Journal of the American Medical Association.*

It is hoped that the winners will be announced by April 15, 1957. The prizes will be: a $200 U.S. Savings Bond for the first place winner; a $100 Bond for the second place winner; and a $25 Bond for each of the third- through tenth place winners. A list of the winners, and some of the winning essays, will be published in the *Bulletin* of the Illinois Society for Medical Research.

The Illinois Society for Medical Research supplies free information on the subject of animal experimentation to all students who request this material for the purpose of entering the contest. Judging by the number of information requests which have been received by the ISMR, this contest will demonstrate the trend of increasing public interest in the methods and achievements of medical and biological research.

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## Blue Shield and the economics of medicine

Why should any doctor take a special interest in his Blue Shield Plan?

For one thing, the physician has a vital professional stake in the success of his own medical pre-payment Plan. This Plan demonstrates the doctor's determination to solve the basic problems of medical economics on terms that will assure him a continuing opportunity to give his patients the best care he is capable of rendering.

Secondly, the Blue Shield Plan is accounting for an ever larger part of the doctor's income. He will want to make sure that Blue Shield provides him with reasonable payments to apply toward his charges for the services that Blue Shield has scheduled allowances.

Thirdly — and perhaps most important — only through Blue Shield can the medical profession continue to control the economy of medical practice.

Blue Shield pioneered the development of prepaid medical care. And, while many other agencies are now providing cash benefits for medical services on an expanding scale, only Blue Shield has an intimate relationship with the physicians themselves. And any profit derived from Blue Shield operations goes to the patient in broader benefits, or to the physician in more adequate payment — not to a third party.

If other organizations unrelated to the medical profession were to take over the entire voluntary prepayment program, then control of the basic economy of American medicine would pass completely out of the hands of the medical profession.

Blue Shield has grown into a big business, in terms of the 37 million people enrolled and the more than $350 millions now paid each year in medical benefits by the Plans. But Blue Shield is big only because the medical profession has a big instrument to do a big job — and the public has given Blue Shield a big reception!

Blue Shield can never be bigger than the profession that created it. It is yours, doctor, to

mold and shape as you will, for the greater good of the people you serve.

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## The medical benevolence fund

In this holiday season I hope that each one of us will be mindful of the Medical Benevolence program of the Illinois State Medical Society and remember that each contribution benefits members of our own group.

No one of us expects to make use of the Fund, for we do not anticipate long illnesses or reverses. Yet we know that at the present time the Benevolence Fund is assisting 40 persons monthly; of these, 14 are physicians and 26 widows. The monthly expense is $2,500. We can be sure that these beneficiaries did not expect the adversities that came to them.

Here are a few facts and figures about the Fund which may not be known to you:

1. The Benevolence Fund was started in May, 1940, and the goal has been to build up a Fund sufficiently large for the interest to maintain the program. To date this has not been accomplished, but we are ever mindful of the goal and are working toward it.

2. The present amount of the Fund is $140,000 in government bonds and, as of September 1, 1956, $53,798.56 in the checking account.

3. The Fund is administered by a committee of doctors appointed by the state medical society's House of Delegates.

4. When a person in need is located, it is reported to the society office — Dr. Harold Camp, Monmouth, Ill.; the chairman is notified, and an investigation is made.

5. Seventy-five dollars per month is the maximum benefit without special action on the part of the Council of the Illinois State Medical Society. If additional funds are needed, the case is presented without mentioning any names, and action is taken by the Council to permit the Committee to pay more than the $75 which the Committee can authorize. It should always be remembered that no one but the members of the committee responsible for the Fund ever know who are the beneficiaries. No name is ever disclosed, and the work of the committee is secret.

6. The primary objective of the Benevolence program is to supplement an individual's income to the best of the ability and interests of all concerned, when an existing need has been determined. No expenses are paid out of this account, and the only checks written against the Fund are payable to recipients. The Illinois State Medical Society pays the committee expense.

7. The maintenance of the Benevolence Fund is shared by the Illinois State Medical Society and the Woman's Auxiliary to the society. Since the amount contributed by the doctors from their dues has been decreased because of the assessment for A.M.E.F., the Auxiliary has been asked to expand its efforts to build up this Fund.

There is joy in sharing with those of our group who are less fortunate than we. Your contributions to the Fund will be gratefully received.

Mrs. Henry F. Berchtold,
Chairman, Benevolence Fund
Woman's Auxiliary to the Illinois
State Medical Society

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HAVE YOU CHANGED YOUR HOME ADDRESS?

Please send the following to: Harold M. Camp, M. D., Secretary, Illinois State Medical Society, 224 South Main Street, Monmouth, Illinois

NAME _____

PLEASE PRINT

| OLD HOME ADDRESS | NEW HOME ADDRESS |
|---|---|
| Street _____ | Street _____ |
| City and Zone _____ | City and Zone _____ |
| State _____ | State _____ |

# Improvements Offered by the Proposed Legislative Revisions of the Coroners' Act

EDWIN F. HIRSCH, M.D., CHICAGO

THE Constitution of the State of Illinois, adopted in 1870, directed that every county shall elect a coroner for a term of four years but did not specify his duties and authority. The Coroners' Act of 1874 defined these duties and responsibilities. Since then the General Assembly has added the following sections to the Coroners' Act: (1) in 1881, three sections concerning coroner's deputies; (2) in 1907, a section on embalming bodies subject to coroner's investigations; (3) in 1909, a section on the removal of a body under investigation from a county; (4) in 1931, a section on inquests; (5) in 1933, two sections on witnesses; and (6) in 1941, a section on coroners in military service. None of these added sections gives specific instructions about the procedures for the necropsy of bodies where death has resulted or is suspected to have resulted from violence or unnatural causes. Accordingly, nothing has been done by direct revisions of the Act of 1874 to improve the quality of the medical examinations for the coroners of Illinois when they are confronted with the problem of determining the cause and means of death in a body referred for investigation.

When the Coroners' Act was placed on the statutes by legislation in 1874, modern scientific aids (forensic pathology) had not been developed. Forensic pathology pertains to the use in courts of law and elsewhere of information gained by the gross, microscopic or other means of examination of tissues with medicolegal implications. It provides the facts by which criminal justice can be established, and by which claims for compensation can be judged. Because pathology has many roots of origin and uses methods prevailing in the basic biological and physical sciences of anatomy, histology, physiology, chemistry, physics, general biology and even botany, the knowledge and technics of any of these basic fields of science can contribute significant facts in the solution of a complex medico-legal problem. A careful necropsy may disclose tissues diseased or injured sufficiently to be the cause of death. From a level of such a direct procedure with definite conclusions can extend a series of increasingly complex examinations which only a scientist with the knowledge and the technics of a specific basic science can make and interpret.

An inclusive system of forsenic pathology, therefore, should have pathologists trained in forensic medicine to make the necropsy examinations as well as the technical facilities for preparing histological sections of tissues. It should have chemical and toxicological laboratories for the detection and quantitative estimation of poisons in tissues. It should be able to call upon experts for significant hematological and serological tests; scientists in biology,

or in physics, or in botany, or on occasion in other specialized fields. Such a coordinated system with methods for collecting, preserving, and integrating factual data by records, imprints, photographs, charts, sketches, and so on, can be a powerful agent in the administration of criminal and social justice of a community.

Because a coroner is required by law to determine (1) the circumstances and (2) the manner whereby a real or suspected homicide has occurred, discussions have centered frequently on the question "should the coroner be a doctor or a layman." There is no argument that most coroners are laymen. Significant reasons for this are political considerations and patronage, the use of the office by some for political advancement, and the poor esteem in which the office is held, a situation that has no satisfaction or appeal to a practicing doctor. The few exceptions are those physician coroners who, stimulated to render a community service, have agreed to accept the duties of the office. A doctor of integrity, good medical training, and with a better understanding of the medical problems encountered in the office can be a forceful coroner. However, the great deterents to a quality physician serving as coroner are the universal public apathy or ignorance of the personnel and organization that such an officer should have, and the traditional mediocrity with which the functions of the coroner's office are regarded generally. This is not to say that there is no good lay coroner and some physician coroners have developed an effective organization.

Probably in all cases referred to the coroner, the most significant element in his responsibilities is to establish the cause of death. This cannot be established merely on the basis of attendant circumstances, nor can it be determined by an external examination only of a dead body, or be untuitively revealed by a casual guess. Lay or physician coroners are not trained to do necropsies, and the coroner appoints a physician to make these examinations. A common presumption in lay and professional circles is that any graduate of a medical school with a license to practice medicine is qualified to make the coroner's necropsies and is able to interpret what he sees during the process. This is a falacious concept of the problem. The average graduate of a medical school has been exposed to only a modicum of gross and microscopic pathology and knows nothing about forensic pathology. A qualified coroner's physician should have the technical ability to make a complete and thorough postmortem examination, a broad background experience in gross and microscopic general pathology in order to distinguish natural death when homicide is suspected; and finally have training in the specialized field of forensic pathology by which he knows about external and internal traumatic injuries of the body, the characteristics of bullet wounds and the nature of the internal injuries that bullets produce, poisoning of all kinds, the detection of minimal lesions as the cause of death, the preservation of data for subsequent presentation in court procedures, and a host of other characteristics acquired with experience that make him a terror to the criminal and a godsend for the innocent.

The Institute of Medicine of Chicago, for many years, has urged legislative improvement of the old Coroners' Act of 1874, and more recently the Chicago Medical Society and the Illinois State Medical Society have joined in this effort. The Illinois State Medical Society in 1952 appointed a committee to examine the possibilities of a constructive revision of the Coroners' Act which would give to the coroners of Illinois, in the discharge of their duties, the advantages of a system of forensic pathology. The members appointed to this committee are Dr. Harlan English of Danville, Dr. C. Paul White of Kewanee, Drs. S. A. Levinson, Franklin Moore and Edwin F. Hirsch (chairman) of Chicago and the legal advisers John Neal of Chicago and Walter Oblinger of Springfield. Toward the end of the Session of the Legislature in 1953, a bill was introduced but not voted upon. In the meantime, the Association of Coroners of Illinois also became interested in a revision of the Coroners' Act of 1874. Representatives from this group and members of the Committee of the Illinois State Medical Society joined in discussion of ideas and concluded that the objectives of both groups should be consolidated into one effort.

Any legislative revision of the Coroners' Act of 1874 must cover all counties of the State. To do this for the large State of Illinois and the great range of coroner work-loads in the separate counties, legislation with a division of counties on the basis of population seemed advisable.

The large population in the county of Cook requires specific arrangements. Accordingly, for legislative purposes counties of more than 500,000 were designated as Class I, and those of less than 500,000 population as Class II.

Two bills, each complimentary to the other, were drafted and on March 9, 1955 were introduced to the General Assembly by Senator Albert Scott of Canton and others. They were designated as Senate Bill 247 and Senate Bill 248. Senate Bill 247 defined more clearly the cases of death which belong to the jurisdiction of the coroner; specified coroner's juries only for cases of suicide, homicide and accidental death, thus saving the cost of unnecessary coroner's juries for a county; provided that the medical examinations be made by a physician duly licensed to practice medicine in all of its branches and wherever possible by one having special training in pathology; and that the appointment of these examiners in Class I counties be by the Coroner while those in Class II be by the Director of the Illinois Department of Public Health in consultation with the elected coroner of each county. Coroners and the Director of Public Health, in this plan, thus cooperate in improving the quality of the medical examinations of coroner cases throughout the State, and in giving groups of counties the benefits of improved medical examiner services, where each alone would have difficulty in obtaining a qualified examiner. Senate Bill 247 included further directives for the medical examination of a death under mysterious circumstances; clearance by the coroner when the body is to be cremated; and several other clarifying instructions.

Senate Bill 248 provided necropsy service to counties of Class II in consultation with the elected coroners through the Department of Public Health. It also specified the appointment of an Advisory Board by the Governor to consider ways and means for improving the quality of these services throughout the State. This Advisory Board of nine members was constituted to include three physicians, three elected coroners and three lay persons acquainted with the problems of forensic medicine.

Senate Bills 247 and 248 passed the Senate by a vote of 29 to 5 and on the final day of the last General Assembly, June 30, 1955 were voted through the House of Representatives 94 to 7 and 94 to 6 respectively.

Governor Stratton on July 7th, 1955 signed Senate Bill 248 but later vetoed Senate Bill 247 on the basis that "a number of pathologists who would not ordinarily be employed by the coroners would be placed no county payrolls by appointment through one of the State Departments. The result would be effectively to destroy county control over the cost and expense of the Coroner's office." This interpretation, however, is not in agreement with the directives covering the qualifications and the appointment of coroner's physicians as specified in Senate Bill 247. A reply by the Illinois State Medical Society's Committee to Governor Stratton's letter informing the Illinois State Medical Society of his decisions on the two bills included the following comments: "It is fair to say that all of the provisions contained in both Bills 247 and 248 came as the result of discussions and pooled experiences of representatives of the Illinois State Medical Society, of the Illinois Coroners Association and of the Illinois Department of Public Health. All groups realized the presence of great defects in the present Coroners' Act which dates back to 1874, and especially in the quality of the medical examinations of coroner cases which everyone, lay and professional, agrees is in the field of medicine."

"In order to help the coroners of the many counties of Illinois in this respect, and to enable all downstate counties to have at least some of this professional benefit, only the minimum requirements for professional skill in necropsy examinations were specified with the hope that a modest beginning would initiate a growing service which, in time, the State of Illinois could look upon with respect and pride."

"The specifications for the coroner's physician performing these functions as set forth in Sec. 10.1 on page 4 of Senate Bill 247 read as follows: "Any medical examination or autopsy conducted pursuant to this Act shall be performed by a physician duly licensed to practice medicine in all of its branches and wherever possible by one having special training in pathology. In Class I counties (Cook) such medical examinations or autopsies shall be performed by physicians appointed or designated by the coroner and in Class II counties (downstate) by physicians appointed or designated by the Director of the Department of Public Health, and in making such appointments or designations

the Director of the Department of Public Health shall consult with the elected coroner in each county."

"None of these provisions orders the use of pathologists as specialists for the necropsy examinations. They only say that wherever possible, physicians with special training in pathology be used, and state clearly that these appointments or designations of physicians to make the necropsy examination be through the Director of Public Health in consultation with the elected coroner in each county. The purpose of this plan was to use well qualified physicians for groups of counties where individual coroners might have difficulty in obtaining this service.

"Inasmuch as you have signed Senate Bill 248 which provides for the appointment of an Advisory Board on Necropsy Service to Coroners in the Department of Public Health, the Illinois State Medical Society and other interested groups earnestly hope that you will appoint soon the members of this Board. This Advisory Board can then investigate thoroughly and make suitable proposals to clarify phases of this service that now seem in doubt."

"An Advisory Board composed of physicians, coroners and lay members, working together, can help realize great improvements in the administration of criminal and social justice in the State of Illinois."

The Committee of the Illinois State Medical Society on the Revision of the Coroners' Act met with representatives of the Illinois Association of Coroners at the Sherman Hotel, Chicago, on October 20, 1956 for conference and discussion on proposed legislation for the next session of the General Assembly. The group suggested several minor changes in the wording of Senate Bill 247 and decided to introduce the revised form into the next General Assembly. The revisions proposed do not change the substance of the original bill. Another joint meeting of these groups will be held in December to adjust any differences of opinion and for clarification purposes.

The passage of the proposed bill and the implementation of Senate Bill 248 that is now on the Statutes can be some of the most significant legislation in medicine and community health for the State of Illinois. All should give enthusiastic support to this effort.

After this report had been prepared Governor William G. Stratton appointed seven of the nine members of the Advisory Board provided under Senate Bill 248.

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## A real service

Many communities are desperate for first class medical and hospital care in their growing towns and territories. Public spirited citizens, churches, service clubs, and other organizations have raised funds for hospital construction. They have offered other attractions for physicians and their families. In many instances, there have been "no takers." This is particularly true in farming areas and the flatlands without tourists, sports, special education, and other pursuits for growing families. The executive secretaries and central offices of state medical organizations can provide a real service to many such communities by informing graduating interns and established physicians of the Sears-Roebuck Foundation Plan. A 10 year, nonsecured loan bearing zero to six per cent interest could be arranged upon demonstration of medical proficiency and need of the community for medical care. *Editorial. Medical Service in the Rocky Mountain Region. Rocky Mountain M.J. Aug.* 1956.

# THE P. R. PAGE

**Edward A. Uzemack, Director of Public Relations**

CHRISTMAS TIME is the one season of the year when just about everyone turns on his best public relations manner. Most individuals seem to go out of their way to do something nice for others; and they find that the act of smiling is not as difficult as at other times of the year.

Each year the observation is made by many persons that this would be a much more pleasant world if the Yuletide spirit could prevail every day of our lives. This dream could become a reality if each one of us would assume as a personal responsibility the perpetual maintenance of good will towards our fellow men.

During the coming year, we in the Chicago office of the Illinois State Medical Society will do our utmost to achieve this goal and to improve our service to the membership. It is our sincerest wish that you enjoy a happy holiday season and a healthful and prosperous year in 1957.

**The personal touch—**

Available for bookings on local television stations after January 1 is a new 28-minute film depicting the "human side" of medicine. Entitled "Even for One," the motion picture was produced by the American Medical Association for use by local and state medical societies.

County societies desiring to sponsor this TV film locally as a public service project should get in touch with the A. M. A. Film Library, 535 N. Dearborn St., Chicago 10, Ill. If you wish to place your order by phone, the number is Whitehall 4 - 1500. There is no charge for the use of the film.

Another new film which will be available after the first of the year is a 30-minute presentation called "The Medical Witness." It depicts the right and wrong methods of presenting medical testimony by re-enacting the trial of a personal injury case.

This motion picture is the first of a series of educational films dealing with the professional relationships of doctors and lawyers. Sponsored jointly by the American Medical Association and the American Bar Association, the series is being produced by the William S. Merrell Co., an ethical pharmaceutical firm of Cincinnati.

The film will be available for showings before medical societies, bar associations and other professional groups throughout the country. Medical societies can obtain it also by writing to the A. M. A.'s film library.

**School for doctors—**

In a recent issue of the Chicago Sun-Times, a veteran science writer, Robert S. Kleckner, made the following observation in the lead of a story on the annual meeting of the Illinois Academy of General Practice:

"Ever wonder what a doctor does when he goes to a convention?

"He may get in a little night clubbing, attend the theater, and have a few highballs, since he never can do the latter while he's on call — and that is 24 hours a day except for infrequent vacations and conventions.

"But mainly his conventions mean he's just going back to school.

" . . . Doctors attending (such conventions) are undergoing intensive postgraduate courses to keep them abreast of the latest in drugs and techniques."

**Idea corner—**

Why not start the new year right by making this PR Page a place for you to crow about your county society's public relations program. Good ideas are always welcome and we'll be glad to present them for all to see. Just drop a note to the Director of Public Relations, Illinois State Medical Society, 185 N. Wabash Avenue, Chicago 1, Illinois.

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## How to detect fraud

Every industrial physician has his own pet methods for detecting and ruling out fraud. The following, while probably familiar to most physicians, are given for what they may be worth:

1. The routine use of a skin pencil for outlining areas of alleged pain or paresthesia is a valuable procedure. By returning to these previously marked areas time after time, discrepancies may be noted.

2. The examiner knows in which areas pain or tenderness may be expected to be present. Such areas as the course of the sciatic nerve in the thigh, the greater occipital bundle, and the medial meniscus, can be closely localized. The malingerer, not knowing these areas quite as well, may betray his hand.

3. In suspected tendon injury, tension placed on the involved tendon will bring out the complaint of pain or absence of it. The response made to a positive Finkelstein's test in De Quervain's disease can hardly be simulated by a malingerer.

4. Muscle spasm, or the lack of it, may indicate the true state of affairs. Experience is necessary for determining the presence of muscle spasm. Often we cannot be sure that it does or does not exist.

5. The presence of callus or inground grime may give us a lead.

6. Absense of atrophy is informative. It must be remembered that atrophy does not take place overnight. We must also remember that measurements of biceps and forearm are greater in the major than in the minor in most persons.

7. Alleged restriction of forward bending may sometimes be checked in both standing and sitting positions and valuable information obtained.

8. The evaluation of grip loss is always difficult. As much depends on the co-operation of the patient, it will be considered along with subjective complaints. There is no machine that will tell us the grip loss without the patient's complete co-operation. Evaluations based on such things as the failure of the knuckles to blanch or failure of forearm muscles to contract are of little value. If there is no muscle power there can be no blanching and no contraction. In the absence of complete co-operation the evaluation of grip loss must be based on many factors among which are amputation, limitation of motion, pain, nerve injury, and muscular weakness from any cause. *J. L. Barritt M.D. The Evaluation of Subjective Disability. Indust. Med. Sept.* 1956.

# CORRESPONDENCE



## History of Medical Practice in Illinois

The full story of how the Illinois State Medical Society was organized, and the mode of living of Illinois pioneers, are among the most interesting features of Volume II of the "History of Medical Practice in Illinois." This book covers the period from 1850 to 1900.

There still is time, if you act quickly, to obtain this volume as a gift for presentation during the holiday season. Copies may be obtained by writing directly to the ISMS headquarters at Monmouth, Ill., or at 185 N. Wabash Ave., Chicago, 1, or by getting in touch with this committee.

Mrs. Manuel E. Lichtenstein
1400 N. Kedzie Avenue
Chicago 51, Illinois

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## Postgraduate courses on diseases of the chest

The Council on Postgraduate Medical Education of the American College of Chest Physicians will present the following Postgraduate Courses on Diseases of the Chest during January-April, 1957:

Vanderbilt University, Nashville, Tennessee, January 14-18

Mark Hopkins Hotel, San Francisco, California, February 25-March 1

Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, April 1-5

Tuition for each course is $75. Recent advances in the diagnosis and treatment of chest diseases — medical and surgical — will be presented.

Further information may be obtained by writing to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

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## Cincinnati Academy of Medicine 100th anniversary

The Academy of Medicine of Cincinnati will observe the 100th anniversary of its beginning with a week-long celebration Feb. 27-March 5 1957. The Centennial Exposition will be held in Cincinnati's historic Music Hall which has attained world renown as the home of the Cincinnati Symphony Orchestra and of the Cincinnati May Festival of music.

There will be a 175-booth exhibition embracing participants from the fields of science, research, medicine, health, community service and related areas of education, business, industry and the like. The Centennial Exposition will be free to the public with special escorted visitation for school children's groups.

Educational movies and informative lectures on medical, science and health subjects will be

given during the Exposition with utilization of the Springer Auditorium facilities accommodating as many as 4,200 at one sitting.

The exhibition of "Juno," a transparent plastic depiction of the female body, will be of wide interest. This educational health exhibit makes clear all the bones, veins, arteries, nerves, lymphatic system and principal internal organs. It has been loaned to the Cincinnati Academy by the Dominican Republic where it has been on exhibit during the 1956 Dominican International Exposition. The "Juno" exhibit which operates with electronic controls, also embraces a message accompanying each 15 minute description of the processes and functions of the various parts of the female anatomy.

The American Museum of Atomic Energy, Oak Ridge, Tenn. is providing a 4,000 square feet exhibit highlighting "Atoms for Peace."

Visiting speakers of the medical profession have been invited to address public evening meetings during the Centennial week.

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## 1957 Mississippi Valley Medical Society essay contest

The attention of physician-medical writers is called to the Mississippi Valley Medical Society's Annual Essay Contest. Any subject of general medical or surgical interest including medical economics and education may be submitted provided the paper is unpublished and is of interest to general practitioners. Contributions are accepted only from physicians who are members of the A.M.A. and who are residents and citizens of the United States. Manuscripts must not exceed 5,000 words and should be submitted in five complete copies, in manuscript style. The winning essay receives a cash prize of $100.00, gold medal, and a certificate, also an invitation to address the annual meeting of the Mississippi Valley Medical Society. (Held at time and place of the American Medical Writers' Association meeting; 1957 meeting, Hotel Sheraton-Jefferson, St. Louis, Sept. 25, 26, 27.) The Society may also award certificates of merit to physicians whose essays rate second and third best. Essays must be in the office of the M.V.M.S. Secretary not later than May 1, 1957. Winning essays are published each year in the January Mississippi Valley Medical Journal (Quincy, Ill.) Further details may be secured from Harold Swanberg, M.D., Secretary M.V.M.S., 209-224 W. C. U. Building, Quincy, Ill.

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## Medical history society meeting

There will be a meeting of the Society of Medical History of Chicago at the Institute of Medicine (Fourth Floor, 86 East Randolph Street) on Wednesday, December 19, 1956 at 8:00 p.m. This is an open meeting. All are welcome. The program will be:

Aldo A. Luisada, M.D.,
Associate Professor of Medicine,
The Chicago Medical School.
Director, Division of Cardiology,
The Chicago Medical School and
Mount Sinai Hospital: The Heart in History.

George Halperin, M.D.,
Associate Editor,
Journal of the American Medical Association:
Theodore Billroth.

Ilza Veith, President
Leo M. Zimmerman, Secretary

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# AT THE EDITOR'S DESK



AN unusual case of fetishism was treated successfully by aversion therapy. The patient, a 33 year old married man, had suffered from the impulse to damage baby carriages and women's handbags ever since he was 10 years old. He had been arrested on many occasions and was finally admitted to a mental hospital. Treatment consisted of giving him an injection of apomorphine and then forcing him to look at handbags and perambulators. This was done every two hours day and night. No food was allowed and at night, amphetamine was used to keep him awake. It worked.

The West Indian Medical Journal reports that in a Jamaica hospital 306 patients were given a mixture of alcohol and chloral hydrate to ease the pains of childbirth. In this country, the mixture is known as a Micky Finn or as knockout drops. The Jamaicans refer to it as a jubilee cocktail. According to one patient: "I still feel the pains, but I don't give a damn."

Bob Graham tells the story of a Christian Scientist who was asked by her bridge club companions, "Didn't you have any labor pains?" The lady answered, "No, but the pressure was terrific."

A news release from the Winthrop Laboratories states that a McComb, Miss., housewife named her new daughter Lilly Alevaire, after the asthma remedy, Alevaire. She did this because she gave the drug credit for saving her life by relieving a serious asthmatic attack during pregnancy.

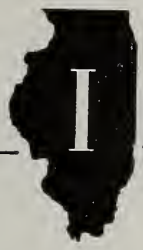
The Florida Citrus Commission found that 76.5 per cent of 16,609 Florida school children drank no orange juice and 74.5 per cent took less than three glasses of milk in their daily diets.

The Jarrell-Ash Company has a new Arithmometer that counts red and white cells automatically in 90 seconds. This will be a break for technicians who are over-burdened with ever increasing dependency upon laboratory tests.

A news release on Monodral was put out recently by the Winthrop Laboratories. They quote Dr. A. Ray Hufford, in the American Journal of Gastroenterology, as saying that Monodral is "more effective than earlier anticholinergics" and that it produced marked inhibition of gastric secretion in patients "frequently to the point of anacidity." The release states that the product was effective and well tolerated in reducing pain and promoting healing in 100 cases of benign ulceration and neuromuscular imbalances of the upper digestive tract.

The Burdick Corporation has a new compact, portable ultrasonic unit that weighs only 25 pounds. The Bendix Aviation Co. also has a new ultrasonic unit that is to be used for cleaning surgical instruments. Cold water or an inexpensive water-detergent solution may be used which, with the help of ultrasonics, will clean the instruments 10 times faster and at one-tenth the cost of hand methods. The cleansing action stems from a cold boil that loosens debris from the metal parts.

# NEWS of the STATE




## COOK

**Lectureship Honors Two Renowned Pediatricians.**—The Drs. Isaac A. Abt—Julius H. Hess Memorial Lecture was delivered, November 20, by Dr. Alfred H. Washburn, Director, Child Research Council, University of Colorado School of Medicine, Denver. His subject was "Watching the Child Become an Adult." The lecture was sponsored by the Chicago Medical Society, Chicago Pediatric Society and Michael Reese Hospital in honor of the late renowned pediatricians who contributed so much to their specialty. Dr. Morris Fishbein opened the program with a review of these two beloved personalities.

**Michael Reese Observes Seventy-Fifth Anniversary.**—"Hospital in Action" is the title of a new book which debuted, Monday, October 15, at a special luncheon for representatives of the press, medical publications and others. The event was a special feature of the seventy-fifth anniversary of Michael Reese Hospital. Authored by Lucy Freeman, the book tells the story of the Michael Reese Medical Center during its seventy-five years' growth. It reveals intimate behind the scenes information of medicine at work. The publication of the book by Rand McNally and Company is but one of a series of events that mark this diamond jubilee for Michael Reese Hospital, where Dr. Morris Kreeger is medical director.

**Emil Grubbe Called Martyr to Science.**—Dr. Emil H. Grubbe, 81 years of age, recently underwent his ninetieth operation for cancerous burns suffered more than fifty years ago when he pioneered as the world's first scientist to use x-rays for human therapy. In this operation surgeons removed his nose and most of the right side of his face. Previously he had lost his left hand, his upper lip and jaw.

Dr. George F. Lull, Secretary and General Manager of the American Medical Association, said in his Secretary's Letter, October 29, "it is seldom, if ever, that anyone can refer to a physician as a "hero" or as "a martyr to science." Then he went on to say that it can be done unhesitatingly in referring to Dr. Grubbe.

Dr. Grubbe was only 20 when he employed x-rays to treat a Chicago woman suffering from breast cancer. The historic event took place, January 29, 1896, at the old Hahnemann Medical College where he first taught as a physicist and later graduated as a physician. The date was only a few months after Roentgen announced the discovery of "the mysterious rays." Dr. Grubbe's original x-ray tubes, the first ones used for therapeutic purposes, are preserved and exhibited in the Gallery of Medical History at the Smithsonian Institution.

**Course in Radiation Physics.**—Northwestern University Medical School will hold its annual Course in Radiation Physics and the James T. Case Lectures for residents in radiology at the hospitals associated with the medical school. As in the past, the course is open to all interested physicians. It will be given on Monday and Thursday evenings from 6:45 p.m. to 9:00 p.m., January 7 through May 7, 1957, in the Morton Research Building, 303 East Chicago Avenue. Tuition fees for residents will be $15, and for practicing and other physicians, $35. Applications should be made to Dr. Edward S. Petersen, Director of the Graduate Division, Northwestern University Medical School, 303 East Chicago Avenue, Chicago 11, Illinois.

**Courses in Technical Fields of Atomic Age.**—Courses in two new technical fields of the atomic age, health physics and radiological physics, will be offered again this winter by the University of Chicago. Increasing use of nuclear materials and radiation sources in research, medical science, and in-

dustry, with accompanying hazards, has created the need for health physicists. These experts, who determine standards of allowable exposure to radiation and direct protective measures, are specialists needed by laboratories and industries using radioactive materials as well as by insurance companies, state governments, and others concerned with radiation hazards. Radiological physicists, also in urgent demand, calculate dosages from radiation sources used in cancer treatment and measure the intensity and type of emissions from radioactive isotopes in research projects. The University of Chicago courses are both two year programs leading to the master's degree. Both courses will be given in the department of radiology of the university's medical center. Physicists, biologists and doctors of medicine will participate in the instruction. During the second year of the courses, students will be employed half-time in either the university's Health Physics Service or in the department of radiology.

**Scholarship Named for Abraham Flexner.**—A $10,000 subsidiary scholarship in honor of Dr. Abraham Flexner has been established at the Chicago Medical School by the Joshua B. and Esther F. Glasser Fund. According to a news release Dr. Flexner is credited with having made "the greatest single contribution to the advancement of medical education in America." His survey in 1910 of all medical schools in the United States and Canada, sponsored by the Carnegie Foundation for the Advancement of Teaching", instituted subsequent surveys by the Council on Medical Education and Hospitals of the American Medical Association which subjected medical education to rigorous discipline. Standards of admission were drastically raised and enforced, making it increasingly difficult for poor or fraudulent teaching to survive. Unapproved schools were eventually closed. In referring to the new scholarship, John J. Sheinin, president of the school, said "in the light of its own struggles to achieve stature as defined in the Flexner study, the Chicago Medical School accepts the Flexner Scholarship with pride and humility. With the acceptance of this honor goes our corresponding responsibility to uphold these same standards."

**John Grayhack Heads New Urologic Laboratory.**—Dr. John Grayhack has been named director of a new laboratory for research in urology at Northwestern University Medical School. The laboratory has been made possible through the Lucy and Edwin Kretschmer Fund. The fund was created in honor of his wife and son by Dr. Herman L. Kretschmer, renowned urologist and formerly president of the American Medical Association and Northwestern alumnus, who died in 1951. An assistant professor of urology, Dr. Grayhack will direct investigation on problems in basic and clinical research relating to the genito-urinary organs. After graduating at the University of Chicago School of Medicine in 1947, Dr. Grayhack studied at Johns Hopkins University Medical School, where he was a fellow of the American Cancer Society, a fellow of the Damon Runyon Fund, and a member of the teaching staff. Before joining the Northwestern staff, he spent two years as a captain in the Air Force Medical Corps at San Antonio, Texas.

**Society News.**—"The Medical Outlook from Washington, D. C." was the title of the presidential address of Dr. Lowell T. Coggeshall before the Institute of Medicine of Chicago, December 4.

**Retires from Practice.**—Dr. John H. Vallancy has retired after thirty-five years in the practice of medicine in Chicago. He and his wife will take up residence in Greenville, Texas, where his son, John C. Vallancy, is now in practice.

**The Hamburger Memorial Lecture.**—The sixth Walter Wile Hamburger Memorial Lecture of the Institute of Medicine of Chicago was delivered, October 22, by Dr. Lewis Dexter, assistant professor of medicine, Harvard Medical School, Boston, on "Valvular Regurgitation."

**Morris Fishbein Honored.**—The 1956 Distinguished Service Award of the American Medical Writers' Association has been presented to Dr. Morris Fishbein, internationally known medical editor. The award is given annually to a member of the association "who has made distinguished contributions to medical literature or rendered unusual and distinguished service to the medical profession."

**New Officers of Specialty Groups.**—Officers chosen at the October 3 meeting of the Chicago Diabetes Association are: Matthew M. Steiner, president; James B. Hurd, first vice president; M. David Allweiss, second vice president, and Jerome T. Paul, secretary. Mr. Melvin C. Holmes is treasurer.—At the annual meeting of the Illinois Society of Pathologists recently, the following were elected officers: Dennis B. Dorsey, president; James W. Henry, first vice president; Herbert P. Friedman, second vice president; Frederick C. Bauer, Jr., secretary-treasurer. The executive council, in addition to these officers, includes Jerry J. Kearns, Lester S. King, David O. Holman and Keith M. Truemner.—Recently elected officers of the Chicago Neurological Society are Drs. Irving C. Sherman, president; Ernest Haase, vice president; Adrien Ver Brugghen, Councilor, and Oscar Sugar, secretary.

**Personal.**—Angelo P. Creticos is now associated with Dr. James H. Hutton in the practices of endocrinology and internal medicine. The office address is 59 East Madison Street, Chicago.—Dr. William A. J. Crane, lecturer in pathology at the University of Glasgow, Glasgow, Scotland, has joined the staff of the Ben May Laboratory of Cancer Research at the University of Chicago.—Dr. Jack Metcoff has been named chairman of the department of pediatrics and director of pediatric research at the Michael Reese Hospital Center.

## DEKALB

**Society News.**—Dr. C. Knight Aldrich, professor and chairman, department of psychiatry, University of Chicago School of Medicine, addressed the DeKalb County Medical Society at the Bishop McLaren Foundation, Sycamore, November 27, on "Psychiatry and the Family Physician."

## DOUGLAS

**Dr. Camp Addresses Rotary Club.**—Dr. Harold M. Camp, Monmouth, Secretary of the Illinois State Medical Society, addressed the Rotary Club in Tuscola, October 23, on "Medicine's Contribution to the People." The Rotary Club was host to the Douglas County Medical Society and ten senior high school students. Another guest was E. A. McMillan, Secretary of the Monmouth Rotary Club.

## DU PAGE

**Society News.**—Edward A. Uzemack, Director of Public Relations and Assistant Secretary, Illinois State Medical Society, addressed the Du Page County Medical Society, November 7, in the Memorial Hospital, Elmhurst; his subject was "The Physician as a Public Relations Man." The society devoted its October 17 meeting to a panel discussion on grievance committee activities. Dr. Harry G. Hardt Jr. was moderator; other speakers were Dr. Kenneth N. Hiatt, Chairman of the Grievance Committee of the DuPage County Medical Society; Mr. Ralph W. Bogardus, Medical Protective Company of Fort Wayne, Ind; Mr. John Woodward the society's legal counsel for the Medical Protective Company, and Mr. Bernard Hirsch, Law Department, American Medical Association.

## LAKE

**Voters Approve County Health Department.**—Results of the recent election assure the establishment of a Lake County Health Department, an issue which has met opposition for years. According to the North Chicago Tribune, North Chicagoans are particularly proud of the health department win, since they look upon it as a means of guaranteeing the end of pollution in Lake Michigan and a check on the spread of conditions which have been allowed to grow at the outskirts of Lake County cities and villages.

**Society News.**—Dr. I. Devore presented a case history on "Vitamin D. Intoxication" before the Lake County Medical Society at its October 9 meeting in the Highland Park Hospital, and Dr. A. Slepyan spoke on "The Laboratory as an Aid to the Dermatologist."

## LOGAN

**Society News.**—Dr. Edward Massie, St. Louis, addressed the Logan County Medical Society at the Hotel Lincoln, Lincoln, October 18, on "Medical Aspects of Cardiac and Cardiovascular Surgery."

## PEORIA

**Diabetes Detection Week.**—The Peoria Medical Society, in keeping with the national observance sponsored by the American Diabetes Association, carried on a local detection and education drive, November 11-17. In addition to setting up various centers in the diabetes detection campaign, the society issued a special letter to its membership which included the following suggestions: Test your own urine today; test each member of your family, and test every patient routinely.

**Society News.**—Dr. Henry C. Sweany, formerly of Chicago and now head of the Missouri State Tuberculosis Sanitarium, Mount Vernon, Mo., addressed the Peoria Medical Society, November 20, on "New Aspects of the Tuberculosis Disease Process as a Result of Antimicrobials."

## ST. CLAIR

**Society News.**—Dr. Stanley Hampton, St. Louis, assistant professor of clinical medicine, Washington University School of Medicine, discussed "Allergy" before the October 4 meeting of the St. Clair County Medical Society. Entertainment for the society was provided by the Diaparene Company. Mr. George Tonek, the company's representative, gave several solo vocal selections and led group singing.

## SANGAMON

**Society News.**—Dr. Edmund B. Alvis, assistant professor of ophthalmology, Washington University School of Medicine, St. Louis, addressed the Sangamon County Medical Society, November 1, at the Elks Club in Springfield; his subject was "Glaucoma."

## VERMILION

**Society News.**—Dr. Isadore Dyer, professor of obstetrics, Tulane University of Louisiana School of Medicine, New Orleans, addressed the Vermilion County Medical Society, November 6, on "Post Cesarean Hysterectomy."

## WARREN

**Crippled Children Clinic.**—Dr. Richard J. Bennett, Chicago, conducted a clinic for the Warren County Crippled Children's Clinic, November 7, at Monmouth Hospital. This clinic has been operating under the auspices of the Warren County Medical Society for approximately thirty years.

## WINNEBAGO

**Annual Smith Memorial Lecture.**—On November 7 Dr. Cecil J. Watson, professor and chairman of the department of medicine, University of Minnesota Medical School, Minneapolis, gave the second Annual Smith Memorial Lecture. His subject was "Some Aspects of Diagnosis and Treatment of Jaundice and Liver Diseases."

**Personal.**—Col. Roland I. Pritikin, M.C., U. S. Army Reserve, Rockford, recently returned from the Eighth International Congress of the History

of Science, Florence, Italy, where he gave two addresses: "History of Treatment of Congenital and Hereditary Eye Defects" and "History of the Introduction to the Management of Mass Eye Casualties Resulting from Radiation Trauma." Colonel Pritikin served as official delegate for the Association of Military Surgeons of the United States, the Industrial Medical Association and the International College of Surgeons.

## GENERAL

**Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:**

**James H. Hutton,** consulting endocrinologist, Illinois Central Railroad, Slim Oaks Club (Branch of TOPS), Oak Park, November 7, on Obesity.

**Ann Fox,** Secretary, Educational Committee, Illinois State Medical Society, Aux Plaines Branch of the Interprofessional Council in Oak Park, October 27, on A Medical Society in Action.

**Roland R. Cross, Jr.,** associate in urology, Northwestern University Medical School, St. Peter's Evangelical and Reformed Church, November 11, on Sex Education.

**Samuel Schwied,** attending physician, Cook County Children's Hospital, Canty School Parent-Teacher Association, November 19, on Problems of Parenthood.

**Lawrence Breslow,** clinical assistant professor of pediatrics, University of Illinois College of Medicine, McPherson School Parent-Teacher Association, November 20, on Health of the School Child in the Second and Third Grades.

**Noah D. Fabricant,** clinical assistant professor of otolaryngology, University of Illinois College of Medicine, Central YMCA Career Day Conference, November 30, on Medicine as a Career.

**Robert S. Mendelsohn,** instructor in pediatrics, Northwestern University Medical School, Chicago Medical Assistants' Association, December 5, on How to Handle Children in a Physician's Office.

**Joseph A. Bertucci,** assistant clinical instructor in pediatrics, Stritch School of Medicine of Loyola University, Child Study Group of the American Association of University Women, December 6, on Physician Care of the Child.

**Frederick Stenn,** assistant professor of medicine Northwestern University School of Medicine. Gage Park Woman's Club, January 8, on Growing Old Gracefully.

**Emerson K. McVey,** member of the staffs of Roseland Community and Little Company of Mary Hospitals, Harding Parent-Teacher Association, January 15, on Understanding the Adolescent.

**William S. Dickerman, Jr.,** Springfield, Chandlerville Woman's Club, Congregational Church in Chandlerville, January 21, on Safe Reducing.

**John B. Hall,** Director, Cook County Department of Public Health, Sixth District of the Illinois Federation of Women's Clubs, January 10, on Poliomyelitis Vaccine.

**Lectures Arranged Through the Postgraduate Medical Education and Scientific Service Committee:**

**William R. Best,** assistant professor of medicine, University of Illinois College of Medicine, Englewood Branch of the Chicago Medical Society, January 8, on Blood Dyscrasias.

**George Milles,** director of the laboratory, Augustana Hospital, Rock Island County Medical Society in Rock Island, January 8, on Pathology of Benign and Malignant Gastric Ulcers.

**Harold A. Quint,** member of the surgical staff at Evanston and St. Francis hospitals, La Salle County Medical Society in La Salle, November 15, on Peripheral Vascular Diseases with Special Reference to Varicose Veins.

**Lawrence W. Peterson,** associate professor of surgery, University of Illinois College of Medicine, Bureau County Medical Society, in Princeton, December 11, on Surgery of the Abdomen.

**Mark C. Wheelock,** associate professor of pathology, Northwestern University Medical School, Henry County Medical Society, January 9, Clinical Pathologic Seminar.

**Frederick Steigmann,** associate professor of medicine, University of Illinois College of Medicine, Kankakee County Medical Society in Kankakee, January 15, on Liver Disease: Diagnosis and Treatment.

**Gordon H. Scott,** assistant professor of otolaryngology, University of Illinois College of Medicine, Stock Yards Branch of the Chicago Medical Society, January 18, on Management of Meniere's Disease.

## GENERAL

**Tuberculosis Declines to New Low.**—The Illinois Health Messenger reported that tuberculosis dropped to a new all-time low in Illinois in 1955 with 898 deaths, or a rate of 9.6 per hundred thousand population. This is the first year in recorded history that Illinois has reported less than 1,000 deaths from this disease. The previous low mark for the state was reached in 1954, when deaths from tuberculosis totaled 1,058, or a rate of 11.6 per hundred thousand population.

Of the 898 deaths recorded last year, 629 were reported from Chicago and 269 from the downstate area. Chicago's 1955 tuberculosis death rate at 17.0 per hundred thousand was more than three times the 4.7 rate reported downstate. When compared with figures for 1954, Chicago experienced a decline in last year's tuberculosis death rate by about 10 per cent, against almost 28 per cent for the downstate area, and 17 per cent for the state as a whole.

Undoubtedly earlier diagnosis of cases and more adequate treatment are factors contributing to these reductions throughout the state. Further improvement could be expected if all active cases of tuberculosis were hospitalized.

It should be noted, the Messenger stated, that the favorable mortality record does not indicate that tuberculosis is diminishing to any extent. Last year 5,814 new active cases of tuberculosis were reported in Illinois. This compares with 5,811 cases in 1954.

**Illinois Physicians Reappointed Governors of Diabetes Association.**—Dr. Ford K. Hick, Chicago, has been reappointed governor for the northern part of Illinois to represent the American Diabetes Association, and Dr. Thomas D. Masters, Springfield, has been reappointed to a similar position for the southern part of the state. The American Diabetes Association established a board of governors a few years ago, representative of each state, to stimulate interest in diabetes and related conditions, as well as facilitate coordination of activities in this field.

**Postgraduate Conferences.**—A Postgraduate Conference was presented at the Clay County Hospital in Flora, October 4, 1956, under the joint cooperation of the Postgraduate Medical Education & Scientific Committee Service of the **Illinois State Medical Society** and the University of Illinois College of Medicine, and with the Clay County Medical Society acting as host.

Dr. F. W. Siegert, Pana, a member of the Postgraduate Medical Education Committee from the Seventh District, presided at the afternoon session which consisted of the following panel presentations: Management of Prolonged Labor; Diagnosis in Acute Abdominal Conditions, and Medical Management of the Cardiovascular Patient. Speakers were Drs. Vincent C. Freda, clinical assistant professor of obstetrics and gynecology; Harold A. Kaminetzky, instructor in obstetrics and gynecology; James A. Schoenberger, assistant professor of medicine; Lindon Seed, clinical associate professor of surgery; Jacob W. Fischer, clinical associate professor of medicine, and Louis C. Johnston, Jr., clinical assistant in medicine. Discussants were Drs. Howard Dillman and Eugene D. Foss.

Dr. L. L. Hutchens, President of the Clay County Medical Society, presided at the evening dinner session. Speakers were Dr. Arthur F. Goodyear, Decatur, Councilor of the Seventh District, on "Current Medical Problems," and Mr. Oliver Field, Director, Bureau of Investigation, American Medical Association, on "Quackeries in Medicine."

The Postgraduate Medical Education and Scientific Service Committee of the Illinois State Medical Society in cooperation with the staff of Henrotin Hospital, Chicago, arranged a postgraduate conference, November 14, in Cairo. Sessions were held at the St. Mary's Hospital and The Hotel Cairo.

Dr. Paul S. Baur, Cairo, member of the Postgraduate Commitee from the Tenth District, presided at the afternoon session which included the following speakers: Roland R. Cross, Jr., member, senior attending staff in urology, "Management of Urinary Infections"; Lawrence Breslow, member of the associate attending staff in pediatrics, "Problems in the Newborn"; James H. Cross, member of the senior attending staff in surgery, "Pre- and Postoperative Care", and Ford K. Hick, senior member of the attending staff in medicine, "Objectives in the Treatment of Diabetes". Included on the afternoon program also was Dr. H. Close Hesseltine, professor of obstetrics and gynecology, University of Chicago School of Medicine, who demonstrated "The Use of Forceps."

At the dinner session, which followed a fellowship hour, Dr. Charles L. Yarbrough, Cairo, presided. Speakers were Drs. Percy E. Hopkins, Chicago, Chairman of the Committee on Medical Service and Public Relations of the state medical society, on "Medicare Program in Illinois", and W. W. Fullerton, Sparta, Councilor for the Tenth District, "Current Medical Problems Today."

Another conference was held in the Illini Community Hospital, Pittsfield, November 8, with the Pike County Medical Society acting as host and with Dr. Joseph J. Grandone, Gillespie, member of the Postgraduate Committee from the Sixth District presiding. This was a panel discussion on "Medical and Surgical Aspects of the Diseases of the Bowel". Participants were members of the faculty of the University of Illinois College of Medicine; Edward A. Newman, clinical instructor in medicine, Medical Aspects; George D. Kaiser, clinical assistant professor of surgery; Electrolyte Disturbances, and James D. Majarakis, assistant professor of surgery, Surgical Aspects. Dr. J. A. Miranda Vargas opened the discussion. Following a fellowship hour at the home of Dr. Jack M. Bailis, dinner was held in the Community Center with James E. Goodman, Pleasant Hill, president of the Pike County Medical Society, presiding. The speaker was Mr. William J. McAuliffe, Jr., Chicago, member of the Law Department of the American Medical Association.

**Conference on Tuberculosis in Industry.**—Health, industrial, labor and business organization cooperated with the Tuberculosis Institute of Chicago and Cook County and the Chicago Association of Commerce and Industry in presenting a conference on tuberculosis in industry, October 17, in the Hotel Sherman. The program was representative of every phase of tuberculosis in industry, from case finding and therapy to rehabilitation.

**Memory of Anton Carlson Honored.**—University of Chicago memorial services for the late Dr. Anton J. Carlson, professor emeritus of physiology, were held November 3, in Rockefeller Memorial Chapel, Chicago. Original plans had been to hold the service in Billings Hospital. Chancellor Lawrence A. Kimpton; Dr. Lester Dragstedt, chairman of the department of surgery; Dr. John Hutchens, chairman of the department of physiology; and the Rev. Carl Wennerstrom, chaplain of the University Clinics; and Dr. Victor Johnson, director of the

Mayo Foundation for Medical Education and Research, and professor of physiology, University of Minnesota, took part in the program. Both Dr. Dragstedt and Dr. Johnson spoke as former students of Dr. Carlson. Dr. Lowell T. Coggeshall, dean of the Division of the Biological Sciences, presided.

**Lectures on Emotional Development.**—"The Medical Practitioner's Contributions Toward Healthy Emotional Development" is being considered in a series of lectures sponsored by the North Shore Health Resort. Forthcoming lectures will be:

**Ralph D. Rabinovitch,** director, Hawthorne Center, Northville, Mich., January 9, 1957, Problems of the School Child.

**Frederick H. Allen,** director, Philadelphia Child Guidance Clinic; February 6, Problems of Teenagers.

**C. Knight Aldrich,** professor and chairman, department of psychiatry, University of Chicago School of Medicine, March 6, on Problems of Adulthood.

**Emily H. Mudd, Ph.D.,** director, Marriage Council of Philadelphia, April 3, Premarital Counseling.

**Robert W. Laidlaw,** chief, division of psychiatry, Roosevelt Hospital, May 1, Marriage Counseling.

**Erich Lindemann,** professor of psychiatry, Harvard Medical School, June 5, on Problems of Grandparents.

The series opened, October 3, with a talk by Dr. Daniel Blain, medical director, American Psychiatric Association, on "The Unique Position of the Physician in Our Society". Dr. Milton Rosenbaum, professor and chairman of the department of psychiatry, Albert Einstein College of Medicine, spoke, November 7, and Dr. Laureta Bender, professor of clinical psychiatry, New York University College of Medicine, December 5. Their subjects were, respectively, "Psychological Preparation of the Individual for Medical and Surgical Care" and "Problems of Early Development."

## DEATHS

**Theresa K. Abt,** retired, Chicago, who graduated at the University of Michigan Medical School in 1892, died October 31, aged 90. She had practiced medicine in Chicago more than 50 years.

**Charles Nicholas Becker*,** Chicago, who graduated at the Chicago College of Medicine and Surgery in 1913, died August 15, aged 72, of carcinoma of the pancreas.

**Richard G. Carlson*,** Beecher, who graduated at the Chicago Medical School in 1948, was killed in an automobile accident, November 9, aged 33.

**Elijah Gillam Davis,** retired, Champaign, who graduated at St. Louis College of Physicians and Surgeons in 1891, died July 26, aged 87, of cerebral vascular accident.

**Andrew A. Dick,** Alhambra, California, formerly of Chicago, who graduated at Magyar Királyi Pázmány Petrus Tudomanyegetem Orvosi Fakultasa, Budapest, Hungary, in 1926, died November 2, aged 54. He had practiced medicine in Chicago from 1938 until he moved to California 3 years ago.

**Stanley Gibson*,** retired, Evanston, who graduated at Northwestern University Medical School in 1913, died October 24, aged 73. He was professor of pediatrics and head of the pediatrics department at Northwestern University before his retirement in 1944 and former chief of staff of the Children's Memorial Hospital.

**Vincenzo T. Indovina,** retired, Chicago, who graduated at Regia Università degli Studi di Palermo, Italy, Facoltà di Medicina e Chirurgia, in 1893, died October 11, aged 89.

**Jacob Jacobson*,** Chicago, who graduated at Loyola University School of Medicine in 1919, died October 17, aged 60.

**Homer J. Junkin*,** Paris, who graduated at the Chicago College of Medicine and Surgery in 1910, died November 5, aged 71. He was for many years a delegate of the Illinois State Medical Society from Edgar County.

**Anthony N. Trapp*,** Chicago, who graduated at Rush Medical College in 1925, died October 14, aged 59. He was a member of the staff of St. Joseph's Hospital.

**Walter T. Venn,** Aurora, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1902, died November 10, aged 78.

**Edmund A. Walsh,** retired, Springfield, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1897, died July 21, aged 81.

**Jeremiah H. Walsh,** retired, Corning, New York, formerly of Chicago, who graduated at Niagara University Medical Department, Buffalo, in 1894, died October 12, aged 86. He was formerly a professor of surgery at Loyola University School of Medicine.

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*Indicates member of Illinois State Medical Society.

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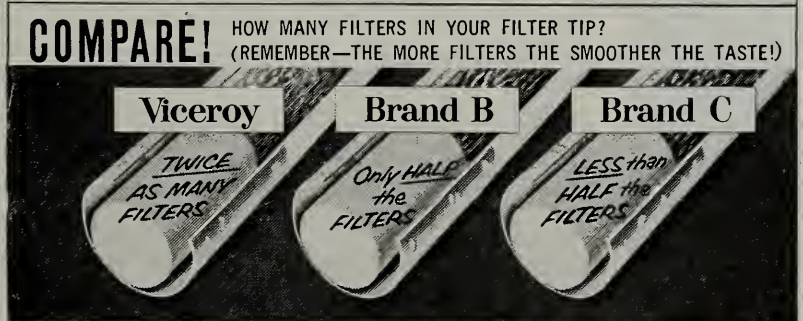



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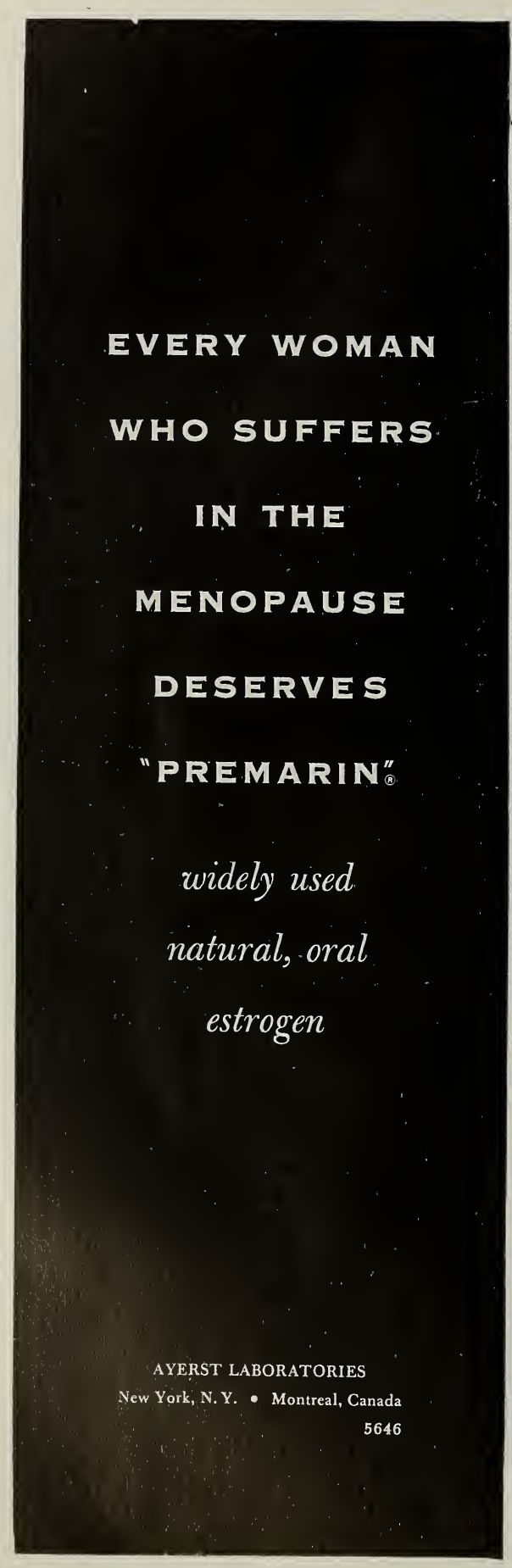
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Funnel chest is a relatively uncommon condition but it occurs frequently enough that it is well to urge early correction of this deformity. Probably the condition is caused by a short diaphragm exerting undue pull on the xyphoid process and the adjacent anterior costal margin. It has been proved that it is not associated with dietary or vitamin deficiency nor with other systemic diseases. If the profession is alerted to its possibility, the condition usually can be diagnosed within the first few months after birth, and when it is diagnosed before the age of 20 months, a simple operative procedure can be used in its correction. This consists of excision of the xyphoid process, with detachment of the diaphragm from the costal margin adjacent to the sternum and xyphoid process. Such an operation requires hospitalization of only several days. A much more extensive operative procedure is necessary after the patient becomes 20 months of age or older. The corrective procedure for the older child or adult includes excision of the costocartilages and an osteotomy of the sternum in order to bring up the chest to its normal position. It is a rather extensive operative procedure but a relatively safe one. The corrective operation for the deformity of funnel chest can be done at any age but the best time is between 4 and 6 years of age. Repair of funnel chest is necessary to eliminate the psychological factor that accompanies such a deformity and to protect cardiac function in years to come. The profession is urged to be on the alert for funnel chest so that it can be diagnosed and treated in early infancy when the operation is a relatively simple one. *Otto C. Brantigan, M.D. Surgery of the Chest Wall. Maryland M. J. July* 1956.

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It would appear that there are well authenticated instances where malnutrition was the only probable cause of a rise in tuberculosis morbidity and mortality, though in most instances it is are also indications that malnutrition becomes operative as an etiological factor in tuberculosis one of several associated possible causes. There only when a critical level is reached. On the other hand, it is recognized that optimum nutrition gives no absolute protection against tuberculosis, if other circumstances are unfavorable. Alton S. Pope, M.D., and John E. Gordon, M.D. Am. J. Med. Sciences, Sept., 1955.

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# BOOK REVIEWS



ROENTGEN SIGNS IN CLINICAL DIAGNOSIS. Author: Isadore Meschan, M. A. M. D. Professor and Director of the Department of Radiology at the Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina; formerly Professor and head of the Department of Radiology at the University of Arkansas School of Medicine, Little Rock, Arkansas. With the assistance of R.M.F. Farrer-Meschan M. B., B. S. Melbourne, Australia. Pages 1058, Illustrations: 2216 on 780 figures. 1956. $20.00. W. B. Saunders Company — Philadelphia and London.

The scheme followed by the author is not that disease entity can usually be specifically diagnosed by Roentgen findings alone with integration of the radiological pathology and the clinical aspects of the patients. He omits for the most part normal radiological anatomy. He presents the Roentgen signs which make up the basic concepts of Roentgen pathology and organizes these criteria to reach a definitive diagnosis, or to suggest a limited number of clinical possibilities.

This volume is made up of 31 chapters. Chapters 1, 2 & 3 deal with the fundamental physics of X-ray, the protection from Roentgen irradiation and the functions of the radiologist. The author here presents some very practical pointers concerning the purchase of an X-ray outfit. The mechanical characteristics that are most efficient for the purchaser's particular needs are enumerated and discussed.

Chapter 4 is an introduction to the radiography of the skeletal system. This is a rather general consideration of such subjects as bone formation, circulation within the bones, signs of bone pathology, changes in contour, size, density and trabecular disorganization. This covers also the determination of bone age and many other conditions of like nature.

Chapter 5 is devoted to fractures of the extremities, epiphyial separation and dislocations. The following chapter considers fracture healing, fracture complications and a general summary of fracture treatment methods.

Abnormalities, congenital and hereditary, of the extremities follows and then comes the subject of radiolucent bone diseases of multiple extremities and next the radiolucent bone disease of a single extremity. Chapter 10 discusses the hardening diseases of bone.

The remainder of the volume follows along specific anatomical items, joints, the skull and facial bones, the vertebral column and the chest. About 120 pages are given to Roentgen findings of the lungs and then another 120 pages covers diseases of the heart.

Detailed information is set forth on the contents of the abdomen with special effort as to the gall bladder, stomach and intestinal tract.

(*Continued on page 58*)



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## BOOK REVIEWS (Continued)

Also Chapter 25 is entirely taken up with the urological tract.

The final chapter covers radiology in obstetrics and gynecology.

The text is very formal, the nomenclature is specific. The bibliography is limited, but to provide sufficient "key" articles are listed additional references.

The presentation of the X-ray film pictures is greatly embellished by small arrows pointing to the lesion. So often in reproduction of films so much contrast detail is lost that the picture on the paper page is useless.

The many diagramatic illustrations depicting the cardinal variations between various diseases, developmental abnormalities or traumatic findings are certainly superb. Their value is differential diagnosis in so far as the X-ray findings are concerned is quite outstanding.

Destructive criticism of this volume is unwarranted. The index is exceptionally well done and covers even minor detailed subjects that are often omitted in other similar volumes.

C. P. B.

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SYNOPSIS OF GYNECOLOGY — Based on the Text Book "Diseases of Women." by Robert James Crossen, M. D., F. A. C. S. Associate Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine, Etc. Fourth Edition. 132 illustrations, 255 pages. $5.25. The C. V. Mosby Company. St. Louis.

This synopsis includes information on the marked advances in gynecology as recorded in the completely revised tenth edition of the Diseases of Women.

This work is quite complete, contains the new concepts concerning gynecological subjects, such as the oogenesis and the development of various ovarian structures; the new ideas on the vascular mechanism controlling the functioning of the ovarian follicles, etc. Many new diagnostic techniques are included.

In the consideration of treatment there is much that is indeed timely. Antibiotics and their effect on infections is adequately presented.

(*Continued on page* 60)




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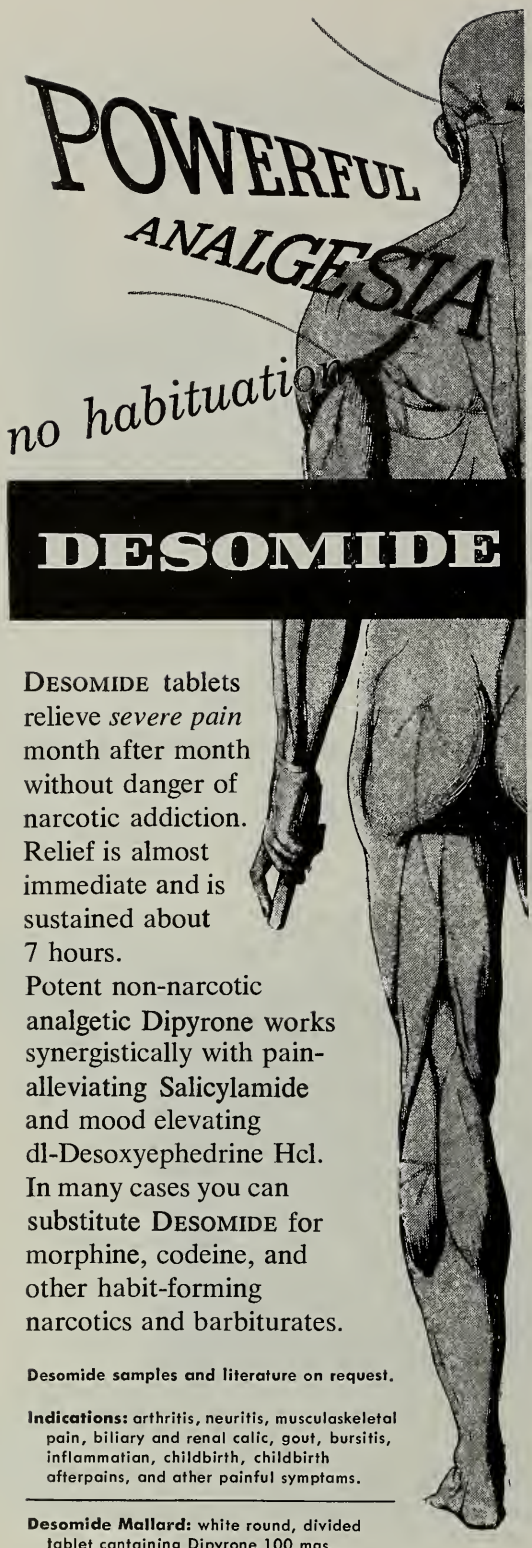
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## BOOK REVIEWS (Continued)

Endocrine disturbances receive deserved attention and of course the functional affections.

In this volume the text must be concise and include all essential facts or else portions of the subject must be omitted. Dr. Crossen has made pointed information on all gynecological subjects in this synopsis.

The book is printed nicely, easily read and the text interesting.

C. P. B.

‹ ›

ESSENTIAL UROLOGY. By Colby. The Williams & Wilkins Co., Baltimore, Md. Price $8.00.

This is the third edition of Dr. Colby's familiar book on Urology. The book retains the same format and makeup, as in previous editions. It appears that there has been an increase in the number of illustrations in the book, making demonstrations of the text more lucid. The author has retained his straight to the point style of presentation and the text is not cluttered with extraneous material. Each section ends with an adequate bibliography of selected references. Preview editions of this book are well known to most serious readers; it certainly is recommended to anyone who wishes an adequate Urological reference.

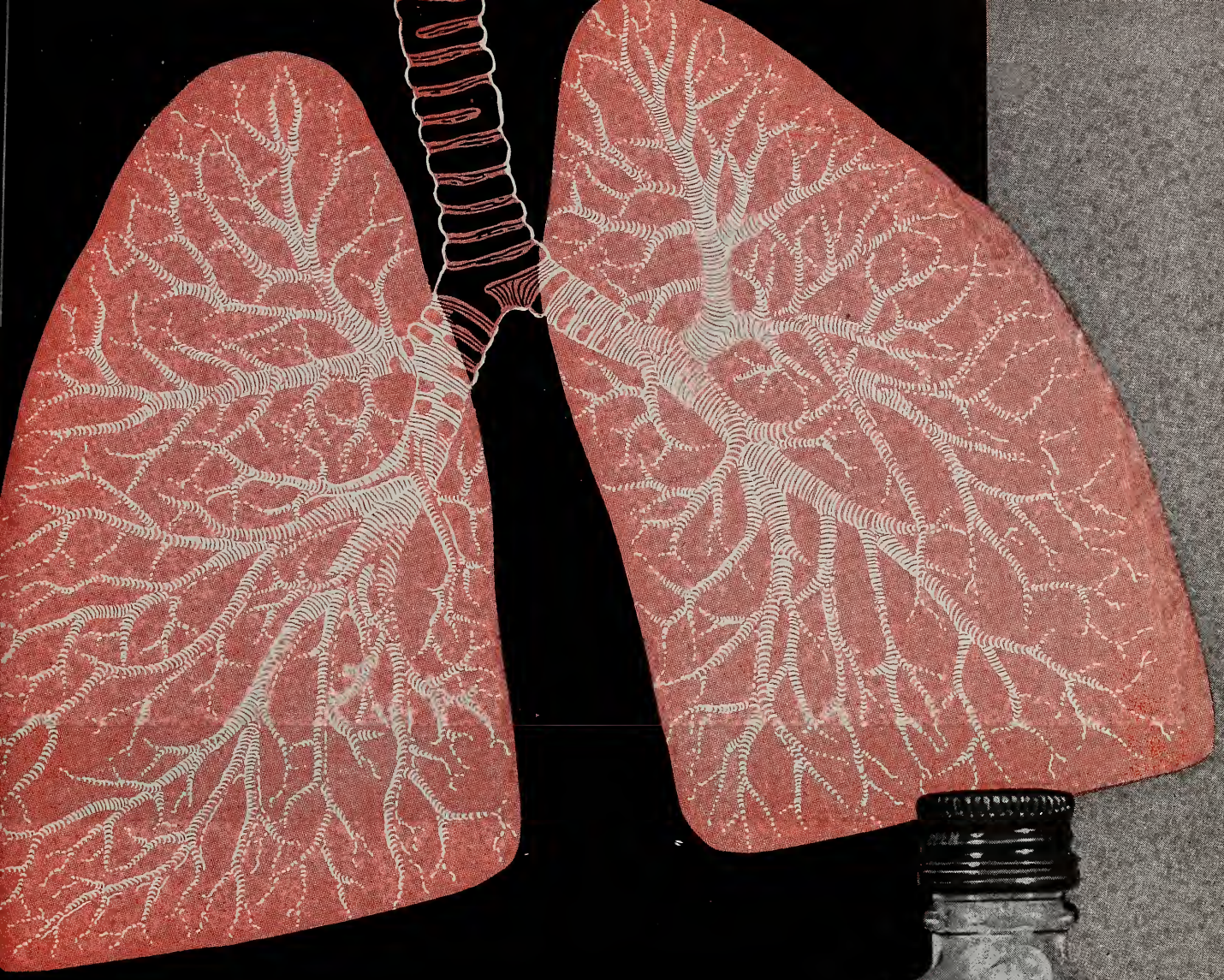
The use of two-tone illustrations, especially the introductory section on, "Anatomy", simplifies greatly the readability of the anatomical drawings.

It is especially recommended that the section on "Malignant Neoplasms Of The Prostate" be read with care, because the author has done an excellent job in presenting this topic in a understandable form. All the important Urological entities are discussed in adequate detail to supply the reader with an above average background in Urology. This book has a place on the shelf within easy reach of any practitioner who has occasion to see a patient with a disturbance of his urinary tract. This would certainly include all practitioners.

‹ ›

CLINICAL UROLOGY FOR GENERAL PRACTICE. Justin J. Cordonnier, M. D. Published by The C. V. Mosby Company, St. Louis, Mo. Price $6.75.

(*Continued on page* 62)



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## BOOK REVIEWS (Continued)

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In presenting treatment the author chooses the paths of conservatism in most instances, and of those topics which there is current divergent thinking as to the proper management, the author recommends that which would be best in the practitioner's hands. This book is well written, profusely illustrated with excellent photographs to demonstrate salient points of the text. It is a book which can be read with ease and to which referral can easily be made for better understanding of the many problems that arise in Urology. It is recommended that this book be found on every practitioner's shelf. There is an adequate bibliography presented in case the curious reader wishes to pursue a subject to its more fine points.

A. T.

‹ ›

## New books at John Crerar Library

BRUGSCH, H. Vergiftungen im Kindesalter. Stuttgart, Enke, 1956 222 p. 618.9 HW614

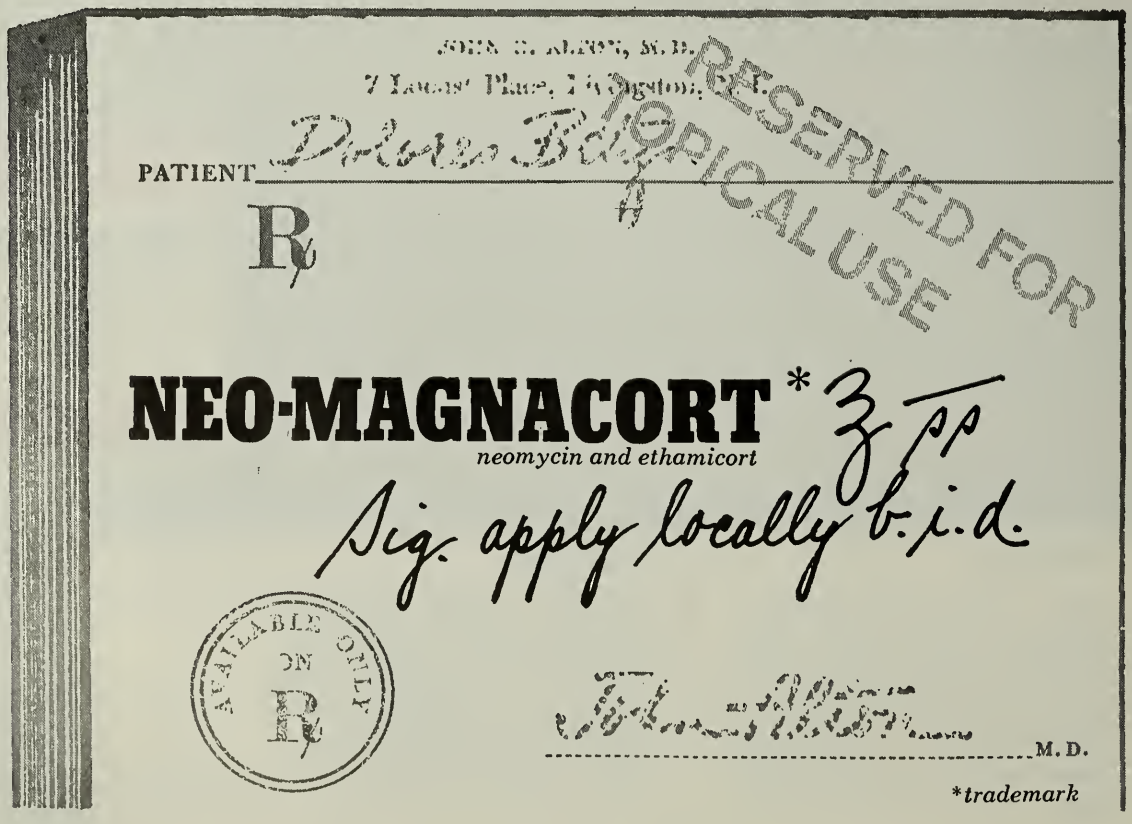
Council for International Organizations of Medical Sciences. The support of medical research. A symposium. Springfield, Thomas, 1956 170 p. MElb 50

DAVIS, M.M. Medical care for tomorrow. New York, Harper & Brothers, 1955 497 p. ME1b 38

DeSANCTIS, A.G. Handbook of pediatric medical emergencies. 2nd ed. St. Louis, Mosby, 1956 389 p. 618.9 HW617

ELLIS, R.W.B. Disease in infancy and child-

(*Continued on page* 64)






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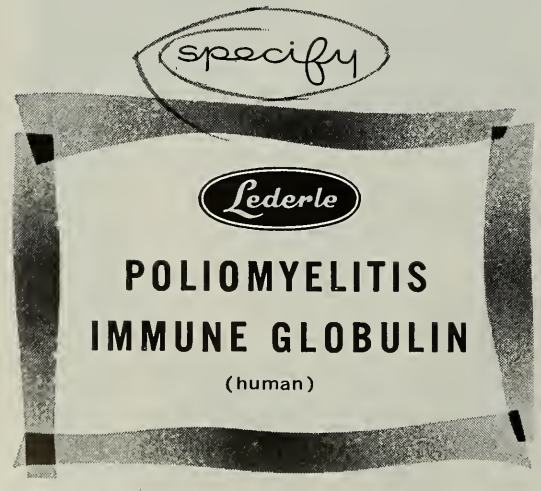
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**BOOKS AT CRERAR (Continued)**

hood, 2nd ed. Edinburgh, Livingstone, Ltd., 1956 710 p. L618.9 HW613

FOOTE, E.J. Six children. Springfield, Thomas, 1956 317 p. 618.9 HW615

HAHN, P.F. Therapeutic use of artificial radioisotopes. New York, John Wiley & Sons Inc., 1956 414 p. ME2b 333

HURLOCK, E. B. Child development. 3rd ed. New York, McGraw-Hill, 1956 703 p. 618.9 HW616

KLINE, M.V. (ed.) Hypnodynamic psychology. New York, Julian Press, Inc., 1955 367 p ME1b 47

NASH, F.C. Breast feeding. 2nd ed. London, Llyd-Luke Ltd., 1956 161 p. 618.9 GW 607

OTTESEN, J. The life cycle of hen erythrocytes. Copenhagen, Munksgaard, 1955 107 p. ME2b 198

PIRIE, A. Biochemistry of the eye. Springfield, Thomas, 1956 323 p. ME1b 51

PRATT, R. and YOUNGKEN, H.W., Jr. Pharmacognosy. 2nd ed. Philadelphia, Lippincott, 1956 694 p. ME2b 342

WELLS, B.B. Clinical pathology. 2nd ed. Philadelphia, Saunders, 1956 488 p. ME2b 350

WILSON, C.O. and JONES, T.E. The American drug index. Philadelphia, Lippincott, 1956 576 p. *615.03 W5

**BOOKS RECEIVED**

PEDIATRICS. Edited by Donald Paterson, M.D., Formerly Clinical Professor, Department of Pediatrics, The University of British Columbia and John Ferguson McCreary, M.D., Professor and Head, Department of Pediatrics, The University of British Columbia. 36 contributing authors. J. B. Lippincott Company, Philadelphia and Montreal, $14.00.

OBSTETRICS. By Nicholson J. Eastman, M.D., Professor of Obstetrics, Johns Hopkins University, and Obstetrician-in-Chief to the Johns Hopkins Hospital. Eleventh Edition. Appleton-Century-Crofts, Inc., New York.

CLINICAL CHEMISTRY, Principles and Procedures. By Joseph S. Annino, Clinical chemist, Massachusetts Memorial Hospitals, Boston, Massachusetts. Little, Brown and Company, Boston and Toronto. $7.50.

LECTURES ON THE SCIENTIFIC BASIS OF MEDICINE. Volume IV, 1954-1955. Distributed in U. S. A. by John deGraff, Inc., 31 East 10th Street, New York 3, New York. University of London, The Athlone Press. $6.50.

UROLOGY AND INDUSTRY. By Leonard Paul Wershub, M.D., F.A.C.S., F.I.C.S., D-I. C.S., D-U. Associate

(*Continued on page* 66)

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## BOOKS RECEIVED (Continued)

Professor of Urology, New York Medical College, Metropolitan Medical Center, New York, New York. Charles C. Thomas, Publisher, Springfield, Illinois. $5.00.

TEXTBOOK OF GYNECOLOGY. By Emil Novak, A.B., M.D., D.Sc. (Hon.) F.A.C.S., F.R.C.O.G. (Hon.) and Edmund R. Novak, A.B., M.D., F.A.C.S. Fifth Edition. The Williams & Wilkins Company, Baltimore, $11.00.

DICTIONARY OF POISONS. By Ibert Mellan and Eleanor Mellan. Philosophical Library, New York, $4.75.

DYNAMIC PSYCHIATRY IN SIMPLE TERMS. By Robert R. Mezer, M.D., Senior Staff Psychiatrist, Community Clinic, Massachusetts Mental Health Center and Harvard Medical School. Foreword by Harry C. Solomon, M.D., Springer Publishing Company, Inc., New York, $2.50.

HEALTH FOR THE AMERICAN PEOPLE, A SYMPOSIUM, presented Monday, November 21, 1955. Massachusetts Memorial Hospitals, Centennial Celebration. Published for Massachusetts Memorial Hospitals, Boston, by Little, Brown and Company, Boston and Toronto.

HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES. By Adolph G. DeSanctis, M. D., Professor of Pediatrics and Chairman of the Department of Pediatrics, Post-Graduate Medical School, New York University-Bellevue Medical Center. With the collaboration of Charles Varga, M. D., Portland, Oregon and 10 contributors. 73 illustrations. Second Edition. The C. V. Mosby Company, St. Louis, 1956. $6.25.

THE NEW YORK ACADEMY OF SCIENCES, 2 East 63rd Street, New York 21, New York announces the publication of the following monographs:

1. Annals, Vol. 64, Art. 2, Some Protozoan Diseases of Man and Animals, Anaplasmosis, Babesiosis, and Toxoplasmosis, by C. Cole and 19 other authors. 250 pages. $3.50.
2. Annals, Vol. 64, Art. 3, Calcium and Phosphorous Metabolism in Man and Animals with Special Reference to Pregnancy and Lactation, by F. McLean and 29 other authors, 192 pages. $4.00.
3. Annals, Vol. 65, Art. 1, Effects of Natural Selection on Human Genotypes, by L. Dunn and 2 other authors, 32 pages. $1.25.
4. Annals, Vol. 65, Art. 2, On the Cell Model for Solutions, by S. A. Rice, 24 pages. $1.25.
5. Annals, Vol. 66, Art 1, Epidemic and Endemic Diarrheal Diseases of the Infant, by E. Neter and 54 other authors. 300 pages. $3.50.

HOME HEALTH EMERGENCIES. A Guide to Home Nursing and First Aid in Family Health Emergencies. Medical Department, The Equitable Life Assurance Society of the United States.

THE MERCK MANUAL. Ninth Edition. Charles E. Lyght, M. D., Editor. Published by Merck & Co. Inc. Rahway, N. J., U. S. A. 1888 pages. Regular edition $6.75. DeLuxe Edition, $9.00.


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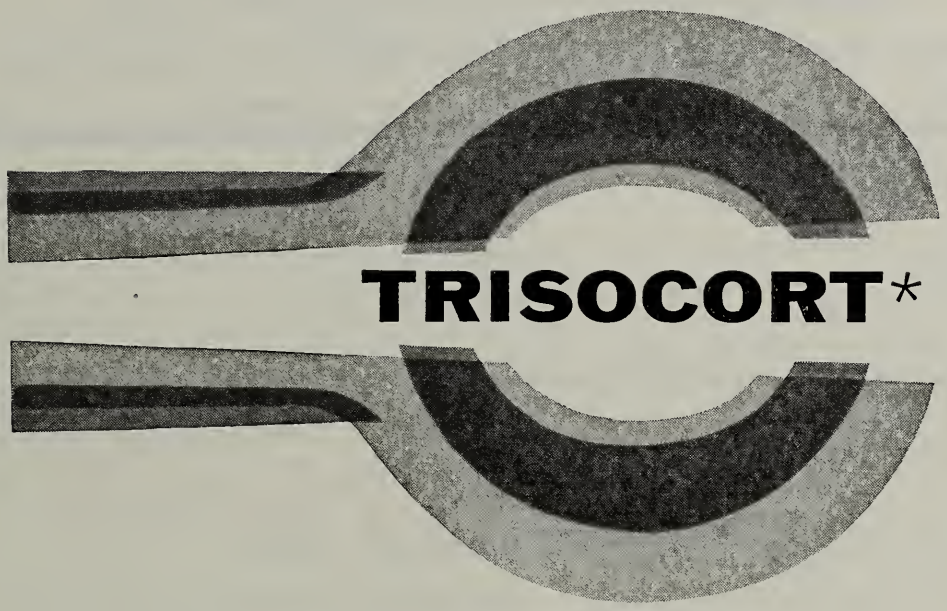



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What gradually has dawned on thoughtful workers and critics is that the beneficial results as well as the complications of frontal lobe surgery bear relation only to the total amount of brain tissue destroyed and not to any particular tracts or fibers sectioned. There is an ever increasing conviction that for practical purposes the frontal lobes may be considered as an equipotential mass of tissue. Personality and intellectual dilapidations increase as more and more tissue is surgically abstracted from the whole. Freeman already admits to this in 1951 when he writes: "It is coming to be realized that only where there is some personality change is there a satisfactory outcome." And Pool and LeBeau have acknowledged this concept, at least implicitly, when they recommend an excision of 20 to 25 grams of cortex for effective conditions but 35 to 50 grams for dementia precox. It follows, therefore, that since brain anatomy is not relevant, any method of graded destruction is suitable. Actually, this is difficult to accomplish by surgical techniques because of vascular injury and might better be accomplished by chemical (procaine) means. *James M. Whitworth, M.D. et al. The Use of Frontal Lobe Procaine Injections. Ohio M.J. July* 1956.

## Paget's disease

My experience in these and other cases shows that Paget's disease must usually affect many bones including some of the long bones, before it is recognized clinically, even in inpatients, unless it is detected by chance during radiographic examination for some other complaint or unless a complication of the disease, such as fracture, bone sarcoma, or, more rarely, cardiac failure of high output type calls attention to its presence. Many patients with extensive disease pass through life undiagnosed because they are never submitted to the scrutiny that follows admission to the hospital. For every case clinically diagnosable there must be at least two persons with Paget's disease in subclinical form that causes neither symptoms nor physical signs and can be detected only by radiological, biochemical, or pathological methods of examination. *Douglas H. Collins, M.D. Paget's Disease of Bone. Lancet. July* 14, 1956.

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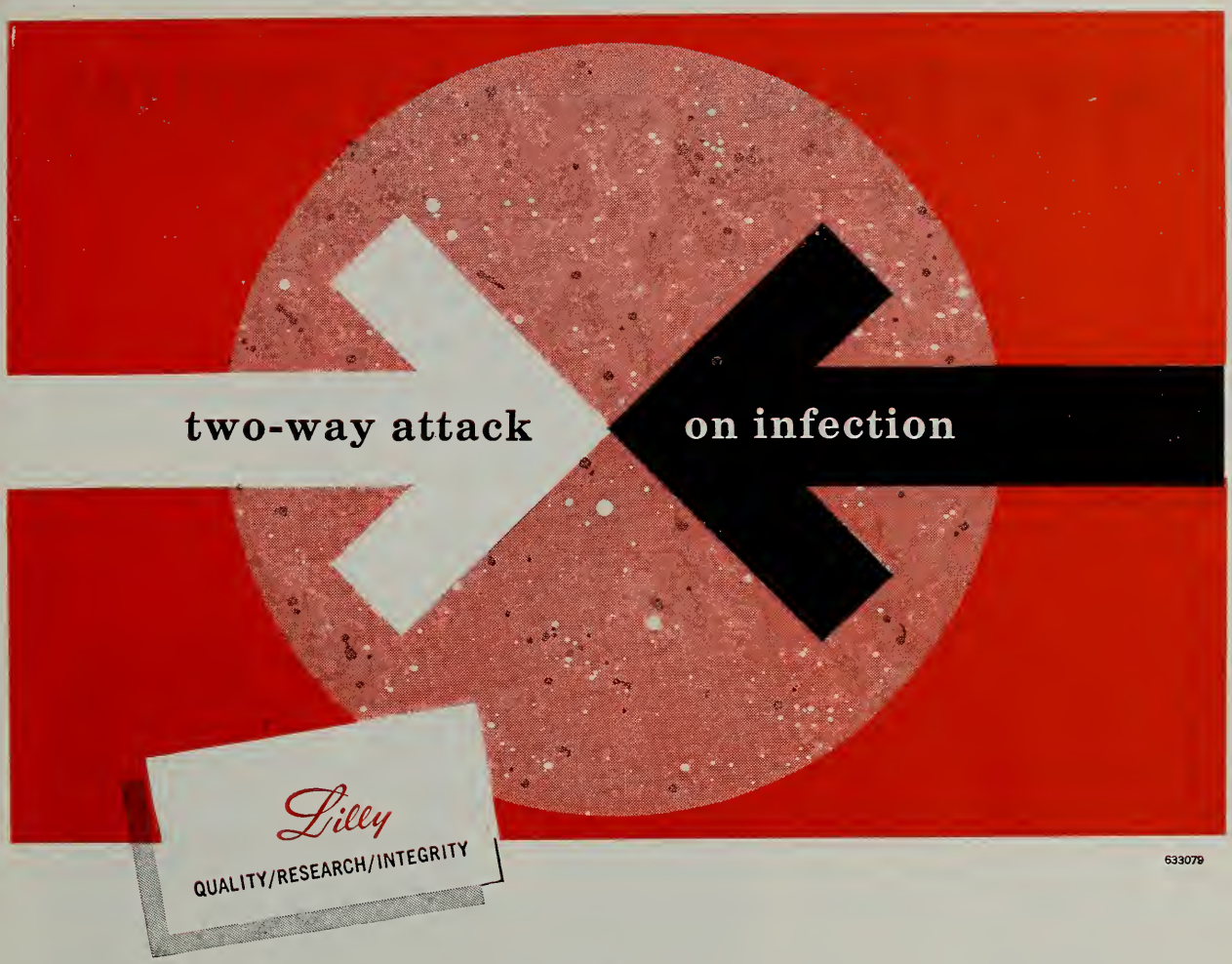

## Early diagnosis of rubella

In conjunction with lymph node enlargement, the results of routine white cell counts are sufficiently characteristic in rubella to permit a confident diagnosis in cases even of subclinical infection, in which symptoms may pass unnoticed. This aid to early diagnosis can be very important when it is necessary to protect a pregnant woman who has been exposed to the infection, by passive immunization. The lymphatic hyperplasias - mainly of the postauricular and occipital lymph nodes - which follows rubella typically and may persist for many months is associated with the presence of Turk cells and plasma cells in the blood. When persistent lymph node enlargement is associated with these blood changes, a retrospective diagnosis of rubella can be made. The fact that all cases of rubella (clinical and subclinical) examined between the first and ninth days showed plasma cells or Turk cells, which nearly always persisted until the sixth week, means that a person not showing these changes is unlikely to have had rubella. In their absence, therefore, there is no need to fear damage to the offspring of a pregnant woman or to consider the advisability of therapeutic abortion. *F. K. M. Hillenbrand, M.D. The Blood Picture in Rubella. Lancet. July* 14, 1956.

‹ ›

## A swap

It seems to be generally true that in individuals who have had allergies from early life symptoms lessen in severity with age or, at times, disappear entirely. This may occur without specific treatment or general allergic management. Loss of symptoms may come about because specific sensitivities tend to have limited duration and wear out, so to speak, although it sometimes takes many years for this to happen. However, while sensitivity to some substances disappears, hypersensitiveness to others may become manifest. There also is the possibility that sensitivity may take a new form — that is, produce a new type of clinical reaction. A patient may cease having nasal allergy from a specific food but may find the same food now produces urticaria or gastrointestinal symptoms. *Solomon Slepian, M.D. and Jacob Reicher, M.D. Allergy in the Geriatric Patient. Geriatrics. Aug.* 1956.




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## Diagnosis of stomach malignancy

Roentgenological diagnosis of gastric cancer is the most accurate. It has been claimed that approximately 90 per cent of gastric cancer can be diagnosed by such means and in only two to five per cent is the X-ray report completely negative. However, Cooper has pointed out that on first examination of 222 cases, only 70 per cent were diagnosed as cancer, with an additional 12 per cent suspect. Furthermore, 85 per cent of these cases were inoperable. Roentgenologic evidence of gastric carcinoma includes filling defects, altered function of the cardia or pylorus, hypermobility, absence of peristalsis, antiperistalsis, and absence of rugal markings. The highest accuracy of X-ray examination has been in detection of lesions on the upper third of the greater curvature. According to Cooper, the error in roentgenologic diagnosis of carcinoma of the cardia is approximately 50 per cent, and few small cancers are detectable by X-ray examination. It has been emphasized that negative reports in case of such lesions may cause a dangerous sense of false security. In studies of 222 gastric cancers measuring 4 cm. or less, Comfort and others reported that roentgenologic diagnosis was positive in 33 per cent and suggestive in an additional 36 per cent. Of 18 lesions measuring 1 cm. or less, only two were diagnosed as cancer and an additional seven were diagnosed as indeterminate lesions. *Cancer of the Stomach. Cancer Bull. May-June* 1956.

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## Dead wood

It seems paradoxical that in the United States, where such a premium is attached to qualifications, and where a multitude of well directed restrictions are administered by a variety of licensing boards, that when one of these initial qualifying hurdles is past, a physician may practice medicine for the remainder of his life without any further educational effort. Realizing full well that legislating study courses is not the ideal solution yet it would appear that some form of established requirements and accreditation might afford some impetus to physicians not prone to take advantage of postgraduate courses. *Melvin A. Caseberg, M.D. The Adequacy of Medical Education. Missouri Med. Aug.* 1956.

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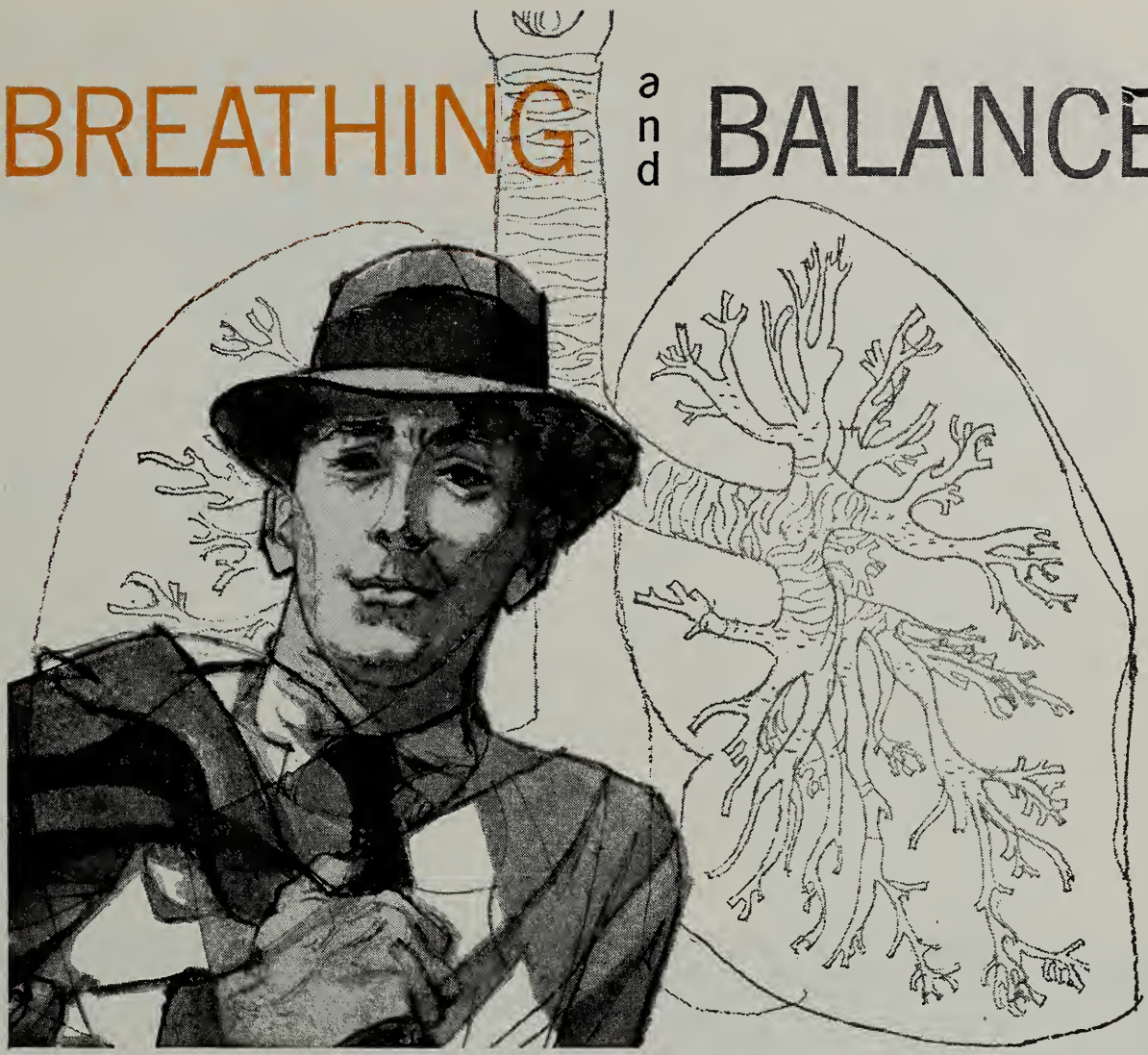
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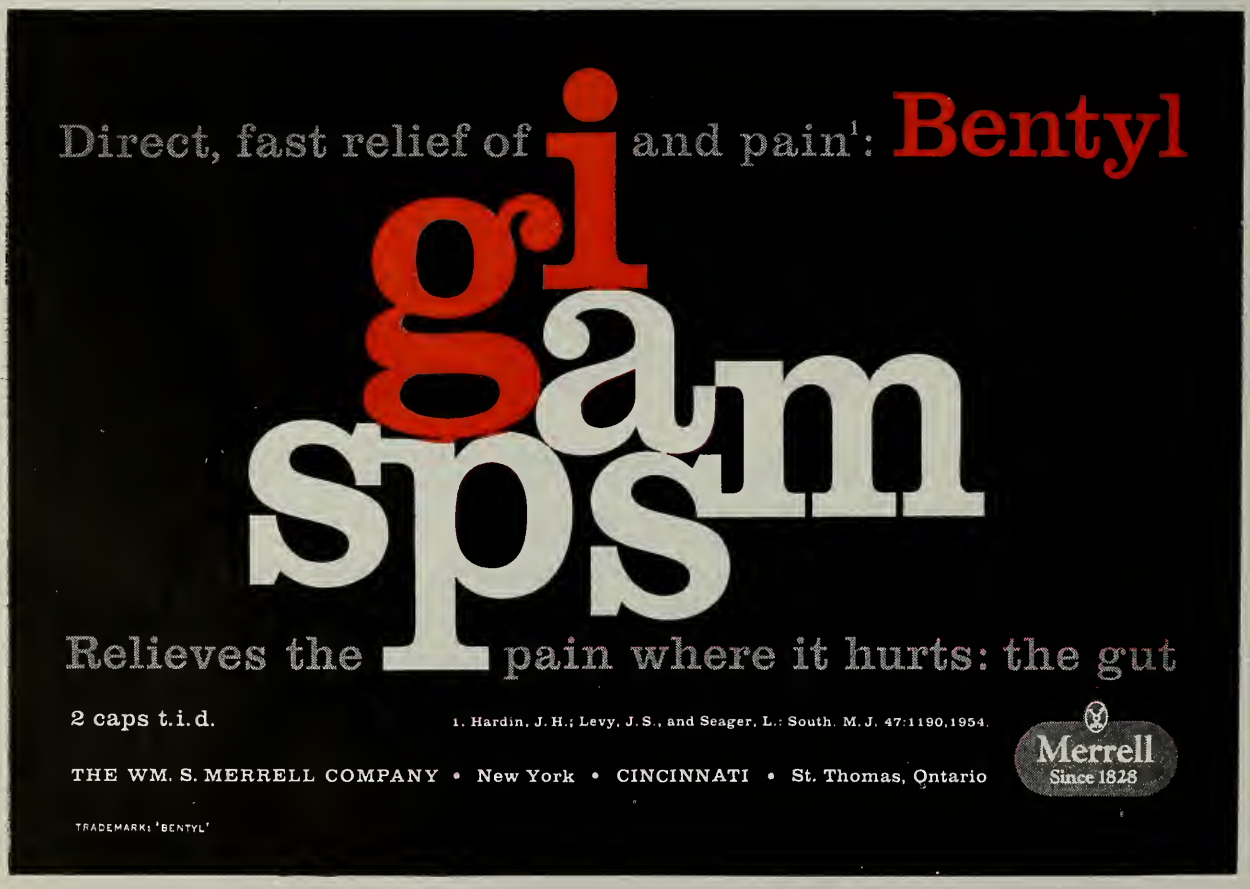
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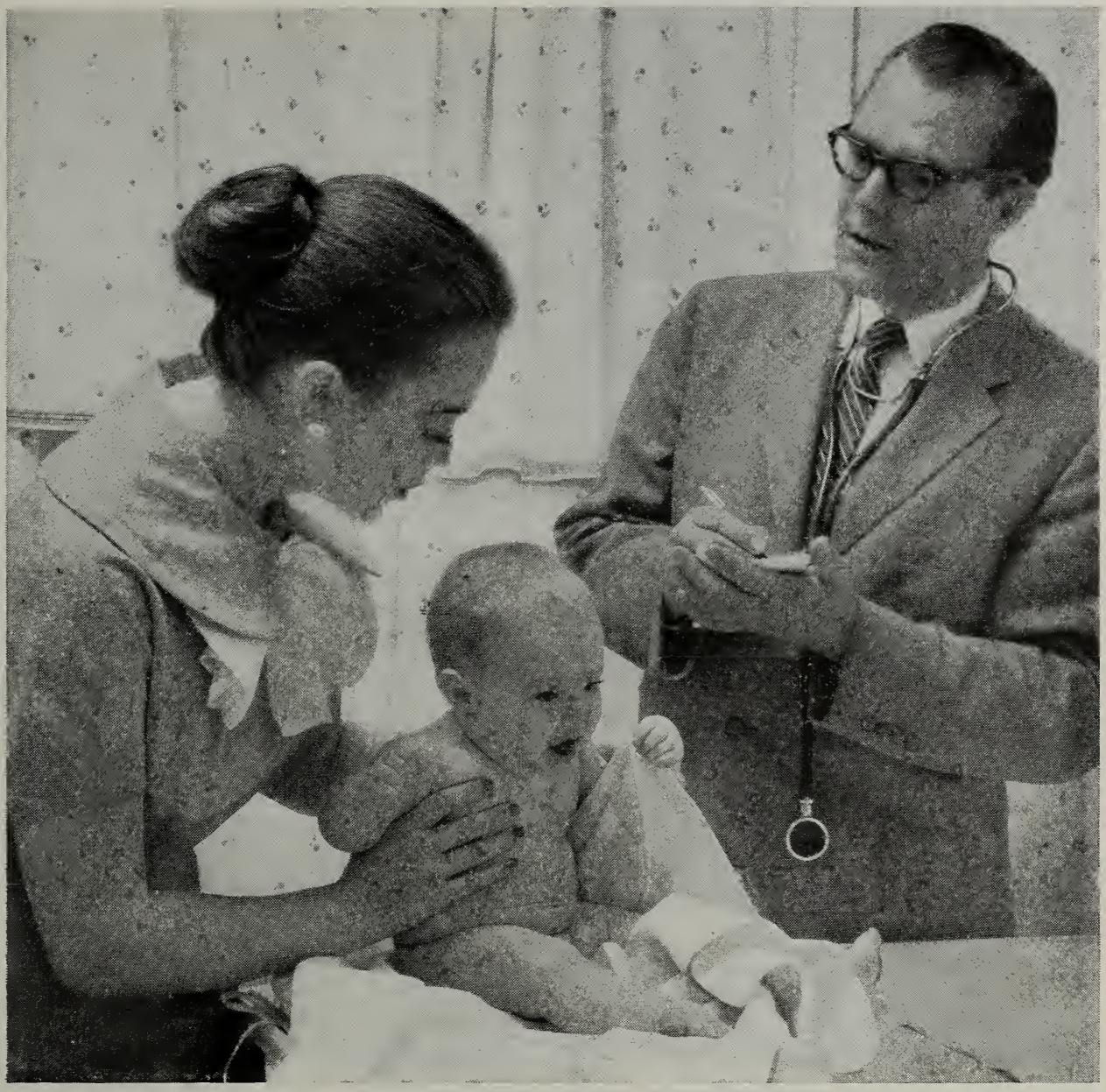
## A lesson in radiology

If one wishes to analyze individual exposures, it is immediately apparent that new medical developments, particularly in X-ray diagnosis, have increased the amount of radiation which the average individual receives in a lifetime to perhaps serious proportions. An examination of the total radiation received in a variety of single routine diagnostic procedures shows the following: Chest, 14 by 17, 0.1 r; Chest, fluoroscopy, 1.0 r; Pregnancy, lateral, 9.0 r; gastrointestinal series, 4 to 50 r; Dental film, 1 to 4 r; Fluoroscopy, 10 to 20 r per minute; Shoefitting fluoroscopy, 1 to 2 r per five second exposure. In the case of the individual with serious pathology such as active peptic ulcer, congenital heart disease, and the like, these examinations are repeated many times within a short interval of time. If one recalls that the dosage of whole body radiation necessary to kill a man is approximately 500 r., it becomes apparent that the continuous repetition of the above dosages to a limited area might have serious effect. Although no detectable damage to the individual has been noted, it must be stated that chronic changes following radiation are very slow in development, and many years may be required for the development of the observed damage. Hence, the causal relationship of late changes can be forgotten easily. *Joe W. Howland, M.D. Ionizing Radiation. New York J. Med. July* 15, 1956.

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The least tangible but probably the most potent factor in the existing favorable trend in mortality from tuberculosis is the general improvement in the standard of living. Greater earning power has made possible more adequate nutrition and better housing. Reduction in the average size of families has reduced overcrowding, which in turn has lessened opportunities for the spread of infection. Where economic levels have continued high, tuberculosis rates have fallen; when war or famine has intervened they promptly rise. It is more than coincidence that the levels of tuberculosis throughout the world are closely related to the economic level of the populations concerned. Alton S. Pope, M.D. and John E. Gordon, M.D., Am. J. Med. Sciences, Sept., 1955.



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## But I'm a doctor!

The *News Chronicle* has described as "one of the phenomena of modern times" the "near deification of the doctor." So that's what has made life so confusing since I qualified. When the patient faces me in surgery he doesn't see me as I am; my face is disguised by the encircling halo.

One evening I locked up surgery and hurried to the bus stop where I re-joined the patient I had just examined.

" 'ello!" he greeted me. "I thought I was the last one."

"Oh?" I said.

"What do you think of that young doctor?" he asked. "I think he's very clever. I've been to see all sorts of specialists at the hospital and they all say there's nothing wrong with me except nerves; but *he's* given me some medicine." He brandished the prescription for mist. acid acetylsalicyl. which I had written two minutes previously.

"What have *you* been to see 'im about?"

"Oh," I said, "Er n-nerves—due to overwork, I think."

He scrutinized my face. "Ah! Very likely," he agreed, nodding solemnly.

This near-deification concept also explains why my prestige seems to drop to zero when someone who doesn't know I'm a doctor is talking to me. I was walking across the courtyard of a large hospital when I was hailed by a lady in an enormous car. I had my white coat on all right but had absentmindedly put down my stethoscope somewhere. The lady shouted:

"Can you tell me where the laboratory is, my man?"

"Which laboratory do you want, madam?" I asked politely.

"I don't know but I'm in a hurry so will you direct me as quickly as you can."

"I think you had better ask at Inquiries, madam."

"Look here," she said, "I haven't got time for that. I'm a doctor. . ."

"Oh," I said. "In that case . . . ." and I directed her to the W. R. laboratory.

Of course, I see it all now. She wasn't really a doctor at all. But she'd heard about this near-deification stuff and was exploiting it. Probably she was securing orders for test tubes or guinea pigs. *In England Now. Lancet, July* 21, 1956.

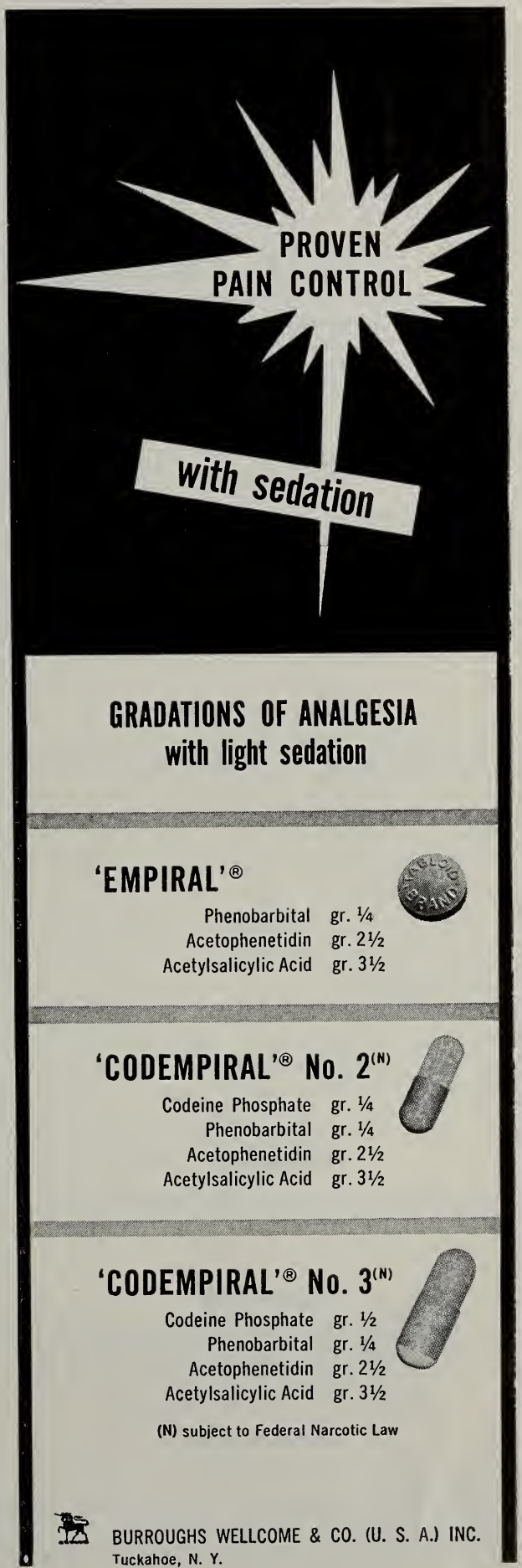
## Study for the gall bladder

As one extends his experience in gall bladder surgery, the less he is inclined to remove the noncalculous gall bladder or the gall bladder that shows visualization but slow and retarded emptying. The results are disappointing. When such gall bladders are removed solely upon the basis of pain and distress, without cholecystographic evidence of disease and without gross evidence of pathology or the presence of stones on exploration, there is likely to be recurrence of distress, a postoperative dyskinesia. It is possible in such cases that small stones in the common duct were present and overlooked; but this is unlikely with gross evidence of disease of the gall bladder or of the biliary tract at the time of operation. Before operating with such questionable symptomatology, other organic diseases such as pancreatitis, posterior wall duodenal ulcer, or functional conditions relating to pylorospasm, irritable colon, or ampullary dyskinesia should be carefully considered. We, like Allen, think little of the necessity of a microscopic slide to make a diagnosis of cholecystitis. Even when cholesterosis is found, cholecystectomy frequently has failed to relieve the patient of symptoms. *Claude J. Hunt, M.D. Gall Bladder Problems. Indust. Med. Aug.* 1956.

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## Five year survivals

The Connecticut Cancer Record Register has information on 75,494 cancer cases diagnosed from 1935 through 1951. Follow-up information reveals that the outlook for survival is improving for some forms of cancer. Marked increase in five year survivals rates were observed for patients with cancers of the large intestine, rectum, cervix, corpus, prostate, and endocrine glands. Both earlier case finding and more effective utilization of available therapeutic techniques apparently were factors in increasing the proportion of cancer patients alive after diagnosis. Effective use of techniques has had a more measurable effect in recent years. Further increase in survival must be predicated on research for better diagnostic and therapeutic methods. *Matthew H. Griswold, M.D. et al. Improvements in Cancer Survival Rates. New England J. Med. June* 7, 1956.

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# 1956
# HOUSE OF DELEGATES

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## SUPPLEMENT
## to the
## ILLINOIS MEDICAL JOURNAL

Sept., 1956

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# HOUSE OF DELEGATES

## First Session May 15, 1956

The first meeting of the House of Delegates of the Illinois State Medical Society was held in the Hotel Sherman, Chicago, on Tuesday, May 15, 1956. It was called to order at 9:25 A. M. by the President, Dr. F. Garm Norbury, Jacksonville.

THE PRESIDENT: Members of the House of Delegates and Guests: We have all subscribed to the oath of Hippocrates. As disciples of Aesculapius we follow his axiom, "We dress the wound, God heals it." Even though this be an organization rather than a clinical phase of the practice of medicine I think we all need Divine help for every phase. Therefore, I ask you to rise for a moment or two while I, a physician not a minister, ask for this help.

Oh God, our Father, lead us and guide us in our deliberations at these meetings so that the things we do will be for the benefit of our patients and our fellow citizens. Make our arguments sound, our decisions wise. Let all our works be in the name of Thee, The Great Healer and Benefactor to all, Amen.

Thank you Gentlemen.

I have a few comments to make. There are according to the Attendance Committee report, 145 men who are giving up their time and energy in the service of organized medicine. I hope all of us will utilize that time to the best advantage. I have the assistance of my distinguished confrere and friend Dr. Warren Furey, to assist me in parliamentary procedure. I have the knowledge and experience of your friend and mine our Secretary, Dr. Harold Camp. I count on both these gentlemen to help me out throughout the meetings of the House. I know many, in fact I hope, most of you. However, I do want you to give your name and county or branch whenever you wish to address the House. I have discussed with Dr. Furey the question of names of movers and seconders of routine motions. He tells me that for these it is legal without having to have those recorded in the proceedings of the House. I do not want to deprive anyone of his place in the sun by not having his name in print. I merely want to save your time in having to have some of us up here search for the person who first made his voice heard. That will not apply to supplementary reports of the Reference Committees or for nominations for office. There, I think, the respective chairmen or proponents should be identified.

I am appreciative of the work the members of the Reference Committees have ahead of them. I am appreciative of your accepting these responsibilities. I would like to have those delegates designated as alternates to Reference Committees attend their respective Committee meetings. This will serve the purpose of a full representative group being present, of the experience of the procedure, and of dissemination through the House of the views expressed. I think it quite legal for you alternates to Reference Committees to attend executive sessions of the Reference Committees too.

I shall endeavor to see that all who wish may have opportunity to express their views in debate on Reference Committee reports. I ask you to keep to the matter at hand for your sake and the sake of all of us. There is nothing personal in your being here or in my being here. We are all working for the best interest of medicine in Illinois. So now I think we had better get on with the job.

The first order of business will be the Report of the Credentials Committee, Dr. Charles Allison, Chairman.

DR. CHARLES ALLISON, Kankakee County: Mr. President, we have 145 delegates that have signed the attendance slips. I move that the number of attendance slips constitute the voting strength of this meeting. (Motion seconded by Dr. Charles Eck, Cook County, and carried).

THE PRESIDENT: The next order of business is the roll call by the Secretary.

THE SECRETARY: Mr. President, I would be very glad to call the roll if it is desired.

DR. EDWIN S. HAMILTON, Kankakee County: I move that the roll call be dispensed with and that the attendance slips be used as the roll call for this meeting. (Motion seconded by Dr. Charles H. Phifer, Cook County, and carried).

THE SECRETARY: We have a gentleman here who has done a great deal for this organization and this particular group. I would like to have him say a few words to you. I would like to introduce Mr. Earl R. Benedict, Convention Manager of the Hotel Sherman.

MR. BENEDICT: We are glad to see you back. We never get tired of seeing you, and I trust we will see you often. I know you have a heavy program, so I will take no more time. Now Mr. President, on behalf of the Hotel Sherman we would like to have you take this gavel back to your home for your grandchildren. I am sure you will not need it with this group.

THE PRESIDENT: Thank you Mr. Benedict.

Gentlemen of the House: It is seldom that we have the privilege and honor of having with us at this meeting the President of the American Medical Association. At different times during the past year I have had the opportunity of being at various meetings with Dr. Elmer Hess. I wrote him last fall asking him on behalf of the Society and myself if he would honor us by being the Banquet speaker. I count it an honor to the State Society and an honor to myself that he accepted. I consider it a great privilege to present to you, Dr. Hess, the House of Delegates of the Illinois State Medical Society.

DR. ELMER HESS: President Norbury and Gentlemen of the House. It is a great privilege for me to be with you at your annual session and to listen to some of your discussions, particularly in the cloak rooms rather than on the floor. I do not think I will get much information from the floor itself but I will hear the arguments out there. Perhaps that is where they should be. Perhaps by the time they get in here, they should be so thoroughly ironed out that the meeting

is steamrollered.

I was terrifically impressed this morning by the President's prayer. I am not a very good person. I was born and raised an Episcopalian but I do not work on it very hard. I have been impressed as I go about the country and meet you men everywhere, in spite of the great push of energy that you put forth to the public where of necessity you must shield yourselves because you are not permitted to allow your emotions to get the best of you when you practice medicine or you would not be in very good shape. When you break that shell you find—I will not say Christian gentlemen but fine, Godfearing men. That is as it should be. I knew only one atheist in traveling up and down the country who had an M. D. attached to his name. I knew one other who claimed to be but in the last year of his life he turned back to the religion of his mother. That is perhaps as it should be.

Here in this House are representatives of the grass roots of Illinois. You represent the thinking of the men in your areas and in your communities. You bring to this House their wishes and their desires in the form of resolutions which have gone down to the local level, where these things are threshed out and decisions made. Every resolution will be referred to a Reference Committee where any M. D. in the State of Illinois may appear and voice his opinion in an effort to sway the opinion of the Reference Committee and the recommendations they make to the body as a whole. No one is denied that voice. The average doctor does not realize that he has that voice and has the privilege of using that voice and should use it. If he does not use it he fails in his duty to his constituents. The report of the Reference committee is brought to the floor of the House where you decide by majority vote whether you will accept or reject the Reference Committee's report. You send your report up to our American Medical Association and again a Reference Committee meets and every doctor in America may appear before that Reference Committee and express his opinion and again by majority vote you may accept or reject what the Reference Committee presents as the House sees fit. So by decree the American Medical Association agrees to carry out the dictum that has come from the grass roots of America. Those of us at national level will carry out your dictates. I have never known a dictate to come from the top down to you. Truly, that is a democratic organization in the fullest sense of the word. Your deliberations are extremely important. I would urge you to do just one thing. No matter how much you hate or disagree with one of your confreres, never permit personalities to interfere with your reason or opinion. It takes big men sometimes to put personalities in the background and decide on a matter on strict morality, for we are big men or we have no right to have the task we have. As a group you are those elected men in any community. We should be leaders in that community not only in medical affairs but in civic affairs. We should assume and take our proper place in community life, not only to take care of the sick but to be interested in everything that will make the community a better place in which to live. As you carry out your deliberations I pray you will use reason and will forget personalities. No matter what happens, no matter how bitterly you have fought, when you go before the public, you will present an orderly front and stand back of the orders you get. May God bless you.

THE PRESIDENT: Thank you Dr. Hess. The next item of business the approval of the minutes of the 1955 annual meetings of the House of Delegates as published in the July and August issues of the Illinois Medical Journal.

DR. CAESAR PORTES, Cook County: I so move. (Motion seconded by Drs. J. M. Pfeiffenberger, Madison County, and Carl Steinhoff, Cook County, and carried).

THE PRESIDENT: Gentlemen of the House: As you know, the Illinois State Medical Society has now for several years recognized one of our members as the outstanding practitioner of the year. This year the Society has chosen Dr. Elbridge W. Telford of DeKalb. I will ask Dr. Clark to escort Dr. Telford to the rostrum.

Dr. Telford has been named the outstanding Illinois pactitioner for the year. A veteran of World War II and also of the war in Korea, Dr. Telford is the eighth and youngest physician ever chosen to receive the award, which is bestowed annually. Dr. Telford, who was graduated from Northwestern University Medical School in 1925 chose to practice in a smaller community although it was the custom then for most new doctors to establish themselves in larger cities. He chose DeKalb on the recommendation of the late Dr. John P. Kane, who had given up a general practice there to prepare for specialization in eye, ear, nose and throat diseases.

Dr. Telford has delivered more than 800 babies. He has gained a reputation as a surgeon and in 1933 was made a fellow of the American College of Surgeons. He was born in Washington, D. C. and moved with his parents to Salem, Illinois in 1904. He studied in grade and high schools there and was closely associated with an uncle, Dr. A. T. Telford of Olney, still in practice there.

After completing his medical education, Dr. Telford served as an intern in Community Hospital, Geneva, and spent two years in Cook County Hospital. When the 33rd Division was mobilized in 1941, he left his practice to join the Division as a First Lieutenant in the Medical Corps. He served in the Pacific Theater and later with General Patton's Third Army in Europe, emerging as a Major in 1945.

In 1947, at the outbreak of the Korean War he helped organize the Medical Staff of the 44th Division as a Lieutenant Colonel in charge of all medical activities. Later he was sent to Korea as Division-Surgeon of the 45th Division. He spent ten of his fourteen and one-half months in Korea in combat areas. This has a personal connotation for me as Dr. Frank B Norbury was Division Psychiatrist on Dr. Telford's Staff.

Dr. Telford, on behalf of the Illinois State Medical Society I give you this certificate as the Outstanding General Practitioner for 1956.

The Illinois State Medical Society makes recommendations to the American Medical Association as regards our Outstanding Practitioner. A book is prepared on the candidate containing various items that are thought of importance in our recommendation, much as in academic circles a curriculum vitae is prepared. We have such a book which I am glad to give to Dr. Telford and Mrs. Telford on behalf of the Illinois State Medical Society.

DR. E. W. TELFORD: Ladies and Gentlemen of the Illinois State Medical Society, Guests, and Other Friends: I come to this event with a feeling of great appreciation to my colleagues of the DeKalb County Medical Society of Illinois for having sent me here, but I cannot be here without a feeling of proper humility when I consider the accomplishments of the thousands of members of our State Medical Society. All of these have given and are giving as much public service in their daily lives as I have given or ever can give.

I have always considered the practice of Medicine a voluntary public service of a high order; *not* to be confused with an *enforced* public service where the patient *must* accept whom he is assigned as his physician.

I want to pay tribute to one of my paternal uncles, A. T. Telford, M. D. of Olney, Illinois, for his early stimulating effect upon me to enter the practice of Medicine. Dr. A. T. Telford is yet in practice at an advanced age, and holds a Fifty Year Medal from this

State Society; to my father, now deceased, and to my mother, yet living I owe much for the stimulation of habits of reading and study and of sound religious faith. Similarly, a maternal uncle, Frank T. Wright, M. D., of Lincoln, Nebraska, whom I saw occasionally in my pre-adolescent years, stimulated my interest in medical practice.

To Northwestern University I also owe much. In fact, with me the University rates equally with the State of Illinois and the United States Government in permitting me to be here; not to mention the Cook County Hospital in Chicago, a sort of medical first love to me.

Last, and of most importance to me, my wife, Helen, in addition to her contributions as a homemaker and social companion, has been the source of greatest aid throughout the rapidly changing times since our marriage in 1926, and in the upbringing of our family all of whom, by their own choice, plan to dedicate their working lives to medical service. My son John is a freshman in Northwestern Medical School; my daughter Annette, married and the mother of my two grandchildren—present count—graduated from the Cook County School of Nursing in 1951; and my daughter Andree, a freshman at Monmouth College this year plans a nursing career.

I shall continue, for as many years as God will allot to me, to pursue to the utmost of my ability, the ancient and honorable practice of Medicine, strengthened and encouraged in this determination by the distinction you have so graciously bestowed upon me and recognizing, with great humility, that, while only one of the members of our Society can be chosen for this award each year, many of you have deserved it, year after year, for many years; in your names as well as mine, I cherish this honor. I am very proud and very humble. Thank you!

THE PRESIDENT: It is a great pleasure to have as our guest this morning Mr. John Hedback, Executive Secretary of the Amercan Medical Education Foundation. We are very proud that Illinois was the pioneer in this movement. I would like to have Mr. Hedback address the House.

MR. JOHN HEDBACK: Thank you Mr. Speaker. Gentlemen of the House of Delegates: I am here primarily to give you information but first I would like to take this opportunity to thank you in behalf of the officers and directors of the American Medical Education Foundation for your leadership throughout the history of the Foundation. Many states are now following this leadership, and I am happy to announce that where Illinois stood alone as a dues-increase state four or five years ago, we now have Utah, Idaho, Nevada and California, and three weeks ago Arizona adopted this increase plan. I have just had word from New Jersey and I understand that last night the House of Delegates of New Jersey followed your leadership. So I can only assure you that though you were the first and you certainly have been alone for a little while, the rest of the country is following your guidance.

The other point of information I would like to bring you is perhaps a matter of clarification. Most of you know that recently through the work and the efforts on behalf of the medical profession and other friends, many people in the country have turned their eyes on the problems of medical education. On April 15, the Ford Foundation in recognition of the efforts of the American Medical Education Foundation and the National Fund for Medical Education announced a program for a ten million dollar matching grant which will be awarded to medical schools in a sliding formula over a period of five to ten years, with a maximum of two million in any one year. This ten million dollars goes to the National Fund for the American Medical Education Foundation. The funds are transferred to the National Fund and matches all un-earmarked and unrestricted funds which will go to medical schools. Any monies there which were raised last year will be matched 100 per cent; in 1956 up to what we matched last year will be matched 70 per cent, so you see every dollar you contribute will be matched by at least 70 cents and at most one dollar. I would like to point out in this respect that they have very specifically stated that they will not match earmarked funds. They will not allow their money to be restricted in any way. Their purpose is to contribute their funds to medical schools in general.

In conclusion, I would like to say that as I look at the figures that come from Illinois I realize that your generosity and your monies have come out of dues. We have many individual contributions from Illinois other than those which come from your dues. I would like to say that Dr. Hess spoke of physicians as leaders in the community. I believe that as far as our Foundation is concerned, Illinois is the leader of those leaders. Thank you Mr. Speaker.

THE PRESIDENT: We are glad to have this information from Headquarters sources. Dr. Camp tells me that Illinois' contribution last year was $189.000, and since its inception about three-quarters of a million has gone from your Society to this American Medical Education Foundation, which is something that I think we in Illinois can be very proud of.

THE PRESIDENT: The next order of business is the appointment of Reference Committees.

## COMMITTEES FOR THE 1956 HOUSE OF DELEGATES

### CREDENTIALS

Charles Allison, Chairman, Kankakee
H. Kenneth Scatliff, Chicago
A. J. Sullivan, Chicago
Harlan English, Danville

This committee will meet in the entrance way of the Louis XVI Room at 8:00 a. m. on Tuesday morning, May 15, to certify delegates—and prior to each of the other two meetings of the House of Delegates scheduled for 1956.

### ATTENDANCE

Winston Tucker, Chairman, Evanston
Joseph F. O'Malley, Chicago
M. J. Kutza, Chicago
H. K. Moulton, Petersburg
B. E. Malstrom, Galesburg

**Alternates:**

E. A. Tappan, Paxton
Robert Dessent, Chicago

This committee will distribute and collect attendance slips, voting slips and act as Sergeants-at-Arms if necessary.

### ON REPORTS OF OFFICERS

To receive and report on the reports of:
1. The President
2. The President-Elect
3. The Secretary-Treasurer

This committee will meet in the Time Room No. 110 at 10:00 a. m. on Wednesday morning, May 16.

Armand J. Mauzey, Chairman, Elmhurst
Charles Eck, Chicago
Russell Jensen, Monmouth
Anders J. Weigen, Chicago
Robert Dunlevy, Pekin

**Alternates**

Henri DuVries, Chicago
Henry C. Turney, Shelbyville

### ON REPORTS OF COUNCILORS

To receive and report on the reports of:
1. The Chairman of the Council
2. The Councilors of the Eleven Councilor Districts
3. The Councilor-at-Large

This committee will meet in the Gold Coast Room No. 111, at 10:00 a. m. on Wednesday morning, May 16.

Percy E. Hopkins, Chairman, Chicago
Allison Burdick, Chicago
Edward Helfers, Chicago
William Scanlan LaSalle
Eugene Johnson, Casey

**Alternates:**

Nicholas Balsamo, Oak Park
S. A. Sinow, Clinton

## ON REPORTS OF STANDING COMMITTEES

To receive and report on the reports of:

1. Committee on Medical Service & Public Relations
2. Medico-Legal Committee
3. Committee on Archives
4. Committee on Medical Education & Hospitals
5. Committee on Medical Benevolence
6. Committee on Medical Testimony
7. Grievance Committee

This committee will meet in the Orchid Room No. 106 at 10:00 a. m. Wednesday morning, May 16.

William Whiting, Chairman, Dongola
A. J. Brislen, Chicago
Fred A. Tworoger, Chicago
Peter C. Rumore, Effingham
William H. Walton, Belleville

Alternates:

S. M. Goldberger, Chicago
Kenneth H. Schnepp, Springfield

## ON REPORTS OF COUNCIL COMMITTEES "A"

To receive and report on the reports of:

1. Editors of the Illinois Medical Journal
2. Editorial Board and Journal Committee
3. Delegates to the American Medical Association
4. Advisory Committee, Illinois Public Aid Commission
5. Advisory Committee, Illinois Occupational Therapy Association
6. Advisory Committee, Veterans Administration

This committee will meet in the Holiday Room No. 105 at 10:00 a. m. Wednesday morning, May 16.

Warren W. Furey, Chairman, Chicago
Wright Adams, Chicago
J. P. FitzGibbons, Chicago
C. D. Swickard, Charleston
David B. Freeman, Moline

Alternates:

Norris J. Heckel, Chicago
M. D. Murfin, Decatur

## ON REPORTS OF COUNCIL COMMITTEES "B"

To receive and report on the reports of:

1. Advisory Committee to the United Mine Workers
2. Advisory Committee to the Woman's Auxiliary
3. Advisory Committee to Selective Service
4. Committee on Blood Banks
5. Committee on Cancer Control
6. Committee on Cardiovascular Disease
7. President, Woman's Auxiliary

This committee will meet in the Emerald Room No. 104 at 10:00 a. m. on Wednesday morning, May 16

Norman L. Sheehe, Chairman, Rockford
Paul Baur, Cairo
H. E. Fehrenbacher, Flora
Warren C. Blim, Chicago Heights
L. S. Tichy, Chicago

Alternates:

E. E. Davis, Avon
H. L. Wallin, Chicago

## ON REPORTS OF COUNCIL COMMITTEES "C"

To receive and report on the reports of:

1. Constitution and By-Laws Committee
2. Crippled Children's Clinic Committee
3. Committee to Study the Coroner's Act
4. Committee on Diabetes
5. Educational Committee
6. Ethical Relations Committee
7. Fifty Year Club Committee
8. Interprofessional Relations Committee

This committee will meet in the Jade Room No. 103 at 10.00 a. m. on Wednesday morning, May 16.

John R. Wolff, Chairman, Chicago
Carl F. Steinhoff, Chicago
Warren W. Young, Chicago
George E. Kirby, Spring Valley
N. A. Thompson, Eldorado

Alternates:

Jack Gibbs, Havana
Clarence A. Norberg, Chicago

## ON REPORTS OF COUNCIL COMMITTEES "D"

To receive and report on the reports of:

1. Committee on Industrial Health
2. Liaison Committee to American Legion (Illinois)
3. Medical Economics Committee
4. Maternal Welfare Committee
5. Liaison Committee on Medical Education
6. Committee on Medical History
7. Committee on Mental Health

This committee will meet in the Jade Room No. 103 at 10:00 a. m. on Thursday morning, May 17.

J. O. Cletcher, Chairman, Tuscola
John E. Bohan, Alexis
William A. Moore, Olney
Karl L. Vehe, Chicago
Walter C. Bornemeier, Chicago

Alternates:

Carl Sibilsky, Peoria
Fred L. Glenn, Chicago

## ON REPORTS OF COUNCIL COMMITTEES "E"

To receive and report on the reports of:

1. Committee on Military Affairs & Emergency Medical Service
2. The Necrologist
3. Committee on Nursing
4. Postgraduate Education Committee
5. Committee on Rural Medical Service
6. Committee on Scientific Work*
7. Committee on Nutrition
8. Joint Commission on Care of the Patient

(* This Committee on Scientific Work has no written report. The committee is composed of the Section Officers charged with the responsibility of planning the program for the annual meeting. This portion of the Reference Committee report should contain a general survey of the meeting, suggestions for improvement of the scientific aspects, any changes which might make the 1957 meeting more efficient, a review of the scientific exhibits, the section meetings, and the General Assemblies.)

This committee will meet in the Orchid Room No. 106 at 10:00 a. m. on Thursday morning, May 17.

James H. Hutton, Chairman, Chicago
L. J. Jurek, Chicago
Robert R. Mustell, Chicago
J. C. Ellis, DeKalb
Tom Kirkwood, Lawrenceville

Alternates:

H. D. Nesmith, Salem
Adrien Verbrugghen, Chicago

## ON MISCELLANEOUS BUSINESS

This committee will receive and report on the reports of the following Committees and also on any other business referred to the Committee by the President:

1. Scientific Service Committee
2. Committee on Tuberculosis
3. Voluntary Plans for Medical & Surgical Care
4. Committee on Polio Vaccine Control

This committee will meet in the Holiday Room No. 105 at 10:00 a. m. on Thursday morning, May 17.

George B. Callahan, Chairman, Waukegan
R. F. Millet, Macomb
Harry E. Mantz, Alton
George Turner, Chicago
Frank F. Maple, Chicago

Alternates:

J. H. Rutledge, Pittsfield
A. J. Linawiecki, Chicago

THE PRESIDENT: The next order of business is the consideration of Annual Reports as published in the HANDBOOK, with supplementary reports as desired.

# Annual Reports of Officers

## THE PRESIDENT

F. Garm Norbury, M. D.

To the Members of the House of Delegates:

This has been a delightful year, a busy one. I have contributed no earth shattering or sonic barrier breaking research to the activities of the Society. I have had a great deal of pleasure and have been conscious of the honor being President. I have worked at a few procedures such as rearrangement of committees, Blue Cross—Blue Shield and retirement programs for the staff, rearrangement of the handbook, inclusion of the traffic safety program at this meeting, correlation of mental health activities.

Component societies, societies in adjacent states, affiliated organizations have shown me the courtesy of asking me to talk to them. Good food, fine hospitality and friendly association have contributed to happy professional and personal relationships as well as adding to my waistline.

So many people have been good to me this past year that I would belie my own request to the Council regarding shortness of reports if I named all of them. I cannot pass by expressing appreciation to our President-Elect, Dr. F. Lee Stone, for making so many meetings not only in the metropolitan area but also over the state for me. I look forward to one of the best years in the history of our Society under him. His experience as Councilor and Chairman of the Council has prepared him in a way few Presidents ever had. His judgement, personality and friendly yet dignified man-

ner will give prestige to the office.

Dr. Harold Camp with his long experience has helped me on many occasions. The staff of the Monmouth and Chicago offices do a tremendous amount of work for the Society as a whole and for individual members. Yet they were never too busy to come to my rescue. My personal thanks go to each one of these fine people.

I have reported to the Council after attending the regular and the interim sessions of the American Medical Association at Atlantic City and Boston respectively. I wish to report to this House what I said to the Council. I am impressed by the stature of the representatives of the Illinois State Medical Society in A. M. A. circles. I saw no group of representatives from other states who approached ours in character, energy and efficiency. The place our people hold in the National activities is evidence of that. I am proud of them.

As always the Illinois State Medical Society is grateful to the members of the Woman's Auxiliary. Their activities in behalf of our Benevolence Fund and the National Fund for Medical Education are of extreme importance. While these activities are significant, the personal influence in the homes and lives of our members and the personal influence radiating into social and community activities is of an inestimable value to our profession.

The Councilors, the stated committees provided in the Constitution of the Society and the Committees of the Council have functioned well. They have all been friendly and gracious to me, hence my appreciation goes to them. They have worked diligently for the scientific and the organization phases of our Society and of the practice of medicine. They and each of us as individuals owe to our patients and to the public the introduction of any helpful procedure. The protection against any procedure that would be harmful is as great an obligation. Legislation, local, state and national, that is beneficial, is approved. Legislation working the other way must be vigorously opposed. We physicians are in a far better position to know what is good for the health of our patients and the public as a whole than even the best informed social workers, theoretical office holders or political office seekers.

I wish to make a comment especially on the activities of the Committee on Postgraduate Education. I believe I can do this because I was the one to introduce the first resolution into this House for the development of the work of this Committee. I have endeavored over the years, and especially during the past two years, to attend as many of the Postgraduate Educational Conferences as possible. When the first of these Conferences was established there was not the demand on the time of the profession for meetings that there now is. The Joint Accreditation Committee had not demanded such frequent meetings of hospital staffs and divisions. The American Academy of General Practice was not established. I believe we in Illinois can be proud of instituting a program that has developed to this extent. Nevertheless that program in its present scope has affected greatly the attendance at our Postgraduate Conferences. I trust that Dr. Limarzi's report, the Reference Committee study and its report to this House will give serious consideration to modification of the present setup.

When I took over the Presidency last May I made a little statement to the House of Delegates. It read in part: "I believe in the private practice of medicine, recognizing that by force of circumstances over which we have no control there are many outside pressures. However, the dignity of man as an individual, the dignity of our honored profession, which over the centuries has put service above self, is the thing we must maintain. As we take care of our patients, as we accept community, state and national responsibilities, thus do we show ourselves in our true light. Our patients, our confreres, our friends and our fellow citizens will then see that we are doing our job and will support us. True we need to see that these others know that we are doing this but our individual actions will, in my personal opinion, count for more in this respect."

I have tried to work and live by that statement over the years and to express it this past year.

Finally I want to thank all of the members of this House for the honor given me. I hope you have stood it as well as I have. My digestion and my legs have stood up fine. My best wishes to every member of the House, to every member of the Illinois State Medical Society and to their families.

Respectfully submitted,

F. Garm Norbury, M. D. *President.*

Illinois State Medical Society.

## THE PRESIDENT-ELECT

To the Members of the House of Delegates:

It has been a great pleasure to serve this past year as your President-Elect. Much of the time I have been glad to assist President Norbury, especially when the events that have occurred were in Chicago. This relieved him of a few of the many duties required of the President.

A few of the highlights:

I represented the Illinois State Medical Society at the Michigan annual meeting in Grand Rapids. I was received there very hospitably and had an opportunity to attend their House of Delegates, which meets prior to the annual meeting without interfering with the scientific program—an idea we might consider for Illinois.

Again with the suggestion of the Industrial Health Commission, I was able to present the activities of that Commission from the point of what the State of Illinois is doing industrial-wise. I have attended many meetings with the Chicago Medical Society Council and all of the State Council meetings.

The Illinois Interprofessional Council at their annual meeting presented a program honoring Mrs. Van der Vries, who has been active in the State Legislature for many years and mostly along medical lines.

Other meetings have been attended, too numerous to mention—one, a meeting sponsored by the Kiwanis Club of Colchester, Illinois, honoring their well known Dr. Harrison, who after his internship in 1909, remained in that city to this time and is loved by all the community. This was excellent Public Relations, indeed.

I regret that I could not be at the Secretaries' Conference held in Springfield on March 25. This meeting was well attended—many Chicago doctors being present.

Several of the postgraduate meetings to which I went were well attended, and the doctors who participated seemed to enjoy the visit with the men in the areas involved.

The one event in which I participated was the postgraduate meeting of the seventh district at Effingham, presented by the Henrotin Hospital group. All of us from Chicago enjoyed the scientific meeting, as well as the social hour following.

On the 10th of April, I was invited to attend the Lake County Society meeting held in Waukegan. The meeting place was the new Nurses' Home adjacent to St. Theresa Hospital, a very beautiful building.

On April 12, groups from the Northwestern University Medical School and the University of Illinois College of Medicine put on a postgraduate program at Monmouth, with the Warren County Medical Society as host. All of the State Medical Society officials were in attendance, and at this time I had the pleasure of visiting the Home Office and seeing the personnel and talking with the young ladies there— it is no

wonder that we have such a fine and efficient group of employees—all one has to do is to talk with them to learn their interest. This same fact is true in the office at 185 North Wabash in Chicago—the entire personnel of the Illinois State Medical Society's offices is very helpful and accommodating.

Monday, April 16, I attended the Illinois Interprofessional Council meeting and presented the report of the Judicial Council of the American Medical Association.

We were very fortunate in having John Mirt help us to the extent he has, and wish him good luck in whatever way he may continue.

The experiences of the past year have given me the opportunity to study the problems of the Illinois State Medical Society and to keep informed. There are many unsolved situations which need exploring. I thank Dr. Norbury for his many suggestions and the help he has given me.

Respectfully submitted,
F. Lee Stone, M. D., *President-Elect.*

## THE SECRETARY-TREASURER

To the Members of the House of Delegates:

The last year has been a momentous one in the operations of the Illinois State Medical Society. Since our last Annual Meeting, important changes have been made affecting the Monmouth and Chicago offices of the Society.

Formerly we had offices on the eighth and ninth floors at 185 North Wabash Avenue. These have been consolidated into one office on the nineteenth floor—a 10-room air conditioned suite. The quarters are being used by the Committee on Medical Service and Public Relations, the Educational Committee, the Committee on Postgraduate Education and the Scientific Service Committee to carry on their operations.

The clerical and mechanical facilities also are available for every other committee and for officers and Councilors who may need these services. It is the business headquarters of the Illinois Medical Journal, and here the editors and Mr. L. E. Malley, business manager, meet weekly to discuss the affairs of the Journal.

A large conference room is provided for meetings of committees and groups which cooperate with the Society, such as the Woman's Auxiliary. Such conferences are held frequently.

### New Public Relations Director

Another important development of the last year was the appointment of Mr. Edward A. Uzemack formerly with the A. M. A., as Director of Public Relations and Assistant Secretary. Mr. Uzemack, who was with the A. M. A. Department of Public Relations and assigned to the President of the Association, now is in charge of the Chicago office. He succeeds Mr. James C. Leary, Director of Public Relattions for ten years before his death more than a year ago.

The secretary is accompanying Mr. Uzemack in trips throughout the state and he gradually is being familiarized with the diversified activities and interests of the Illinois State Medical Society in 102 counties and covering more than 9,900 physicians. He is gaining knowledge of the many types of services being rendered by the medical profession in all parts of the state.

Mr. Uzemack hopes to visit all parts of the state in the coming months. He has attended the postgraduate conferences in Monmouth, Decatur and Mattoon, the Secretaries Conference and other meetings. As he becomes better acquainted with physicians all over the state and recognizes the problems which we face nationally, statewide and locally he will be able to present constructive programs to the State Society and to County Medical Societies.

When Mr. Leary suffered his first coronary 18 months ago, Mr. John A. Mirt stepped into the breach and carried on for three months. With the death of Mr. Leary, he again took over the public relations activities until such time as a successor was appointed. He had the able assistance of Clara Mai Rutherford, who had been Mr. Leary's secretary and who now is secretary of the Medical Service and Public Relations Committee and Committee on Postgraduate Education.

With the consolidation of the Chicago offices, the secretary continued as office manager. He made at least one or two visits a week to Chicago. When he was not there, Mr. Mirt functioned in the capacity of manager. He has assisted in the publicity for this meeting. We are grateful to Mr. Mirt for his cooperation and fine work over the last 18 months.

The Chicago office has a most loyal employee in the person of Mrs. Kathryn Simmons. Back in 1916, Mrs. Simmons' father, Dr. Henry G. Ohls, was assistant editor of the Journal. When the Council asked Dr. Ohls to hire a part-time stenographer, he selected his daughter. She became a full-time employee more than 30 years ago. She is the office receptionist and switchboard operator and assists in the activities of the Educational and Scientific Service Committees.

The Chicago office also has a stenographer whose services are available to any officer or Councilor who may drop in, as well as to the committees which function there. Two college students, working part time, take care of the work shop.

### Monmouth Office

In the Monmouth office, we have four full time assistants to the secretary, who have worked for the best interests of this Society for an aggregate of 50 years. Each has her specific duties but when there is an unusually large mailing to members they work as a team. It is not unusual for them and your secretary to mimeograph, fold, address, seal and stamp 10,000 pieces of mail in one day.

During the last year, more mail has been sent from this office than ever before. Previously, our stamping was done by hand with the use of stamps. Last summer, an automatic postal meter was acquired. This and an automatic addressograph and a new folding machine have made it possible to get out the added work without increasing the clerical force.

It is planned to equip the Chicago office with some of this time saving equipment.

All correspondence relative to membership, remittances from component society secretaries, reports of death of members, as well as reporting of new members, must come to the Monmouth office. All membership cards are sent to members and releases from time to time to the entire membership are handled there.

Papers to be submitted for publication in the Illinois Medical Journal first come to the Monmouth office where they are acknowledged, and recorded. Then they are taken to Chicago where the editors look them over, and if found acceptable, they are given to the business manager to be sent to the press. This procedure will be described in the report of the editors elsewhere in this handbook.

When postgraduate conferences are set up anywhere in Illinois a letter of information as to the date, place it is to be held and the speakers who have been scheduled as well as their subjects, go to each of the physicians in the host and surrounding counties two weeks before the meeting is to be held. Then a week previous to the date of the conference, the official program and a return postcard is sent to the same mailing list, the card addressed to the secretary of the host society to enable him to make the proper arrangements for the meeting, and also to estimate the number who will be present for the dinner. This policy has been in force since the first P. G. Conferences were scheduled 19 years ago. All bills against the society must be sent to this office where the records are

maintained and from which all bills are paid.

Frances C. Zimmer, our oldest employee who is on her 20th year with the Society, has been designated as the executive assistant to the secretary and is in charge of the Monmouth office during his absence. Your secretary is grateful for the work of his clerical force in the Monmouth office and for their interest in their respective duties.

PHYSICIANS PLACEMENT SERVICE

We are proud of the Illinois State Medical Society's Physician Placement Service which has been under the supervision of Jane Zimmer Swanson for the last 14 years.

More than 10 years have elapsed since V-J Day. In retrospect it is interesting to note that the activities of the Physicians' Placement Service, which it was assumed would terminate soon thereafter, have taken quite a different course. It is true that the objectives of the program have been altered, but the volume of correspondence handled in connection with this program is still on the increase, contrary to all expectations at the close of World War II.

Fortunately the distribution of physicians throughout Illinois is more equitable than in many states. However, there are a good many rural communities where additional general practitioners could be used to good advantage. We find that most physicians desire to locate in areas having up-to-date hospital facilities, and this preference seems to overshadow the financial attractions of the small towns. Whenever possible we try to point out to the communities concerned that it is their responsibility to cooperate in making the proper facilities available to physicians.

This office insists that physicians who register with our Physicians' Placement Service furnish complete biographical data before our services are made available to them. The information entered by the physicians is confirmed by the A. M. A. before the physician in question is added to our mailing list. Likewise, we insist that complete information concerning the communities to be listed with our office be furnished before consideration is given to the listing of the community with our service. The information submitted is verified by other material in our office, as well as by a report requested from the secretary of the medical society in the county in which the community is located.

Unfortunately too many physicians neglect to notify us when they have found suitable locations. Similarly we fail to receive notification when certain openings for physicians are filled. Recently we have been attaching forms to our bulletins being sent to the mailing list of the Physicians' Placement Service to be used in notifying us as whether or not they wish to remain on our mailing list. Stamped addressed envelopes are enclosed with these forms, and this has resulted in increased returns. The bulletins referred to are mailed monthly and occasionally more often, depending on the number of openings that have been call- to our attention since the previous bulletin was sent out.

Semi-annual reports concerning the activities of the Physicians' Placement Service are sent to the Council on Medical Service of the A. M. A. These reports are included in the Council's report to the Committee on Extension of Hospitals and Other Facilities and to the House of Delegates. In these reports we include such information as the total number of requests from physicians seeking assistance in finding locations, the total number of physicians who have located in our state since the last report, the number of communities that have sought assistance from our office, the number of these communities that have obtained physicians, etc. The report covering the period July 1955 to January 1, 1956, indicated that 20 communities that had sought the assistance of our Physician's Placement Service had obtained physicians.

Recently we have divided the stencils of our mailing list into two groups: 1) the native born physicians who are graduates of class "A" medical schools. 2) the alien physicians. Some communities specify that they prefer native born physicians and in these cases the bulletins concerning them are not sent to the alien physicians. The inability of the alien physicians to secure staff privileges at some hospitals continues to present a major problem to the physicians themselves and likewise to our office. Many hospitals require county medical society membership of their staff members and since alien physicians are not eligible for membership in the society, we find that many of them are trying to practice without hospital affiliations.

The Secretary's Office welcomes suggestions from members as to communities that should be listed as needing additional physicians.

SECRETARY'S NEWS LETTER

Eight years ago, we began sending the monthly News Letter to the officers of all county and branch societies, members of the Council and officers of this Society. Within a relatively short time we had so many requests from members to get on the mailing list, that your secretary turned over the responsibility of getting out this bulletin to Frances C. Zimmer.

Currently we have a mailing list of about 1,000 receiving the regular issues. Many of these requests have come from physicians prominent in the A. M. A., and several other organizations. Complimentary letters have been received from physicians receiving the issue regularly. We have noted that quite a number of society bulletins, and some medical Journals have commented on our efforts and have republished or abstracted some of the contents of the News Letter. We were assured by the President of the A. M. A. that he appreciated receiving the News Letter and read it carefully each month.

Any member of this Society desiring to be placed on our mailing list need only to write to us asking that this be done.

We do have the opportunity of proofing all copy before it is set up, and occasionally add our own comments in the News Letter, but Mrs. Zimmer is the one to be thanked for the release each month.

THE COUNCIL

Your secretary has attended all meetings of the Council during the past year, and in fact he has not missed a single Council meeting since his election as Councilor for the Fourth District in 1922. As would be suspected, there has been a great change in the type of work done by the Council 30 or more years ago, and that of our Council today. The problems are different and with complete agendas for each Council session, much more work can be done in a shorter time than was previously the case.

We urge the members of this House of Delegates as well as component society officers to attend a meeting of the Council and see what these members do for the best interests of the medical profession of Illinois. Two members live so far from Chicago that it actually keeps them away from home and their practice for two full days to be present for the Sunday Council meetings. It is indeed rare that a member misses a meeting, and then only for a good reason.

Since the last annual meeting of this Society, the Council has held seven regular meetings which have required the major portion of the day for each of them. Many problems have been submitted to the members by mail when a quick reply seemed necessary, and many of the problems which have arisen have been acted upon quickly by mail.

1956 ANNUAL SECRETARIES' CONFERENCE

The Annual Conference of the secretaries and other officers of component Societies was held at the Leland Hotel, Springfield, on Sunday, March 25. The program was well arranged, the attendance was good. It was the hope of those present that the Coun-

cil will approve a similar session at about the same time in 1957. It was also the desire of the group that Springfield again be selected for this annual conference.

Springfield is more easily accessible from all parts of the state than any other city in central Illinois. It is accessible by rail, automobile or by air, and a meeting there permits those in attendance from any part of Illinois to reach home in good time the same evening.

### Increasing Duties of the President

Not too many years ago, the president of the Illinois State Medical Society made a few visits to some of the larger component societies during his term of office, then presiding at the annual sessions of the House of Delegates.

In recent years, our presidents have been going to all parts of the state to meet with many societies, and have received many invitations to appear on programs at meetings of allied professional groups. He has visited a number of annual meetings of adjoining state societies during this year.

Our retiring president, F. Garm Norbury, has been on the road a good part of the time which has continued from his inauguration last May, until the opening of this 116th Annual Session.

During recent years the president-elect has received an excellent indoctrination by attending many meetings, and frequently pinch hitting for the president in attending other meetings on days the president is appearing at another place.

We believe that this is not only the best exemplification of his fulfilling the duties of his office, but is also a fine type of public relations.

### Something for The Future

Since Mr. Uzemack will be in charge of the Chicago office, your secretary for the time being plans to be there each Tuesday. When he becomes better acquainted with his duties, it may not be necessary to make so many trips.

Our records show that your secretary in the last fiscal year spent about 100 days in the Chicago office. Other meetings and necessary trips around the state required another 50 days.

One week in April, I was away six consecutive days, arriving home for a few hours rest late each night. We had one postgraduate conference on Wednesday at Elmhurst and one at Jacksonville the next day, both of which I attended.

We hope that next year more postgraduate conferences will be held during the fall and fewer conferences close to the annual meeting. Such an arrangement should add materially to the attendance as well as to the interest in these conferences.

In several of our county societies an annual meeting is arranged which is attended by members of the medical, dental, pharmaceutical and legal professions. With so many mutual problems within these professions, it seems to your secretary, that similar meetings should be arranged in many other counties of Illinois.

We also believe that physicians should arrange meetings occasionally with the press, at which time many problems could be discussed to a good advantage. This has been done in several states. The reports received from them show such meetings are bound to pay good dividends to both groups.

Your secretary also thanks the component county secretaries for their fine cooperation. We probably sent them more letters during the last year than ever before, as we had questionnaires and letters in which we asked for expressions from secretaries. The response always was prompt and highly satisfactory.

Releases from the A. M. A. and other sources were sent to them to be passed on. The cooperation was an important factor in carrying on the ever-increasing functions of the secretary's office.

To the four assistants in the Monmouth office—Mrs. Frances C. Zimmer, Jane Zimmer Swanson, Wanda Ross and Mary Ward—and to the Chicago office staff—Ann Fox, Clara Mai Rutherford, Kathryn Simmons and Kathleen Burke—my thanks.

### Membership Data

For several years we have been hoping to report a total membership of 10,000 members. We are steadily going toward that goal, but are still short of this aim. We are again pleased to report a steady increase in membership during the past year. The membership report given is for April 23, 1956, as it was necessary for us to close the books on this date in order to meet the deadline for annual reports to be published in the handbook.

| | | |
|---|---|---|
| Membership as reported for May 1, 1955 | | 9,857 |
| New members during the year | 492 | |
| Reinstatements | 151 | |
| Omitted in error | 2 | |
| Total | | 645 |
| Dropped during the year: | | |
| Died | 180 | |
| Moved from state | 139 | |
| Resigned | 8 | |
| Non-payment of dues | 185 | |
| Suspended | 3 | |
| V. A. and Miscellaneous | 24 | |
| Total dropped | | 539 |
| Membership on April 30, 1956 | | 9,963 |

In conclusion, your secretary expresses his gratefulness to the members of the House of Delegates, the Officers, Councilors, committee members and the membership in general for the helpfulness in making the secretary's position a pleasant one. Without the united support of all these, the work could not have been carried on.

Respectfully submitted,

Harold M. Camp, M. D.
*Secretary-Treasurer*

### Financial Report of the Secretary-Treasurer
Fiscal Year Ended April 30, 1956

RECEIPTS FROM COUNTY SOCIETIES

| | | | |
|---|---|---|---|
| Adams | $ 4,290.00 | Edgar | 910.00 |
| Alexander | 585.00 | Edwards | 130.00 |
| Bond | 260.00 | Effingham | 1,430.00 |
| Boone | 650.00 | Fayette | 715.00 |
| Bureau | 325.00 | Ford | 1,690.00 |
| Carroll | 715.00 | Franklin | 1,430.00 |
| Cass | 715.00 | Fulton | 2,710.00 |
| Champaign | 8,352.50 | Gallatin | 00 |
| Chicago Medical Society | 383,057.50 | Greene | 650.00 |
| Christian | 1,365.00 | Hancock | 1,170.00 |
| Clark | 520.00 | Hardin | 00 |
| Clay | 520.00 | Henderson | 325.00 |
| Clinton | 910.00 | Henry | 2,147.50 |
| Coles-Cumberland | 2,990.00 | Iroquois | 1,430.00 |
| Crawford | 650.00 | Jackson | 2,145.00 |
| DeKalb | 2,275.00 | Jasper | 195.00 |
| DeWitt | 1,300.00 | Jefferson-Hamilton | 1,970.00 |
| Douglas | 1,820.00 | Jersey | 455.00 |
| DuPage | 10,272.00 | JoDaviess | 390.00 |
| Kane | 12,740.00 | Johnson | 195.00 |
| Kankakee | 4,770.00 | Perry | 1,040.00 |
| Kendall | 845.00 | Piatt | 585.00 |
| Knox | 3,185.00 | Pike | 650.00 |
| Lake | 10,687.50 | Pope | 00 |
| LaSalle | 6,110.00 | Pulaski | 520.00 |
| Lawrence | 780.00 | Randolph | 910.00 |
| Lee | 1,690.00 | Richland | 1,105.00 |
| Livingston | $ 1,940.00 | Rock Island | 7,605.00 |
| Logan | 1,495.00 | St. Clair | 16,197.50 |
| McDonough | 1,300.00 | Saline | 1,170.00 |
| McHenry | 3,770.00 | Sangamon | 9,620.00 |
| | | Schuyler | 00 |

| | | | |
|---|---|---|---|
| McLean | 5,882.50 | Shelby | 585.00 |
| Macon | 6,630.00 | Stephenson | 2,405.00 |
| Macoupin | 1,560.00 | Tazewell | 2,650.00 |
| Madison | 8,125.00 | Union | 715.00 |
| Marion | 1,820.00 | Vermilion | 5,525.00 |
| Mason | 422.50 | Wabash | 715.00 |
| Massac | 130.00 | Warren | 845.00 |
| Menard | 195.00 | Washington | 455.00 |
| Mercer | 455.00 | Wayne | 715.00 |
| Monroe | 455.00 | White | 845.00 |
| Montgomery | 845.00 | Whiteside | 2,080.00 |
| Morgan | 3,250.00 | Will-Grundy | 9,360.00 |
| Moultrie | 325.00 | Williamson | 1,657.50 |
| Ogle | 1,365.00 | Winnebago | 12,675.00 |
| Peoria | 11,582.50 | Woodford | 715.00 |

| | |
|---|---|
| Total | $615,359.50 |
| General Fund | $170,659.00 |
| Benevolence Fund | 18,928.00 |
| Educational Fund | 189,310.00 |
| A. M. A. Dues | 236,462.50 |
| Total | $615,359.50 |

RECEIPTS AND PAYMENTS
Fiscal Year Ended April 30, 1956

RECEIPTS

| | | |
|---|---|---|
| Component Societies: | | |
| General Fund | $170,659.00 | |
| Benevolence Fund | 18,928.00 | |
| American Medical Educational Foundation | 189,310.00 | |
| American Medical Association Dues | 236,462.50 | $615,359.50 |
| Subscriptions—Journal | | 459.80 |
| Advertising—Journal | | 113,951.04 |
| Exhibits—State Meeting 1955 | $2,635.00 | |
| Exhibits—State Meeting 1956 | 7,815.00 | 10,450.00 |
| Interest on Government Bonds | | 2,328.00 |
| American Medical Association Collection Service | | 2,432.76 |
| Sale of Medical Histories | | 4,528.50 |
| Chicago Medical Society Rental of Lights | | 150.00 |
| Refunds—Postage | | 103.63 |
| Refund—Annual Meeting Expense | | 75.95 |
| Refunds and Miscellaneous Receipts | | 15.64 |
| Total Receipts | | $749,854.82 |
| Cash Balance May 1, 1955 | | 208,872.98 |
| Total | | $958,727.80 |

PAYMENTS

| | | |
|---|---|---|
| Secretary's Office Expense | | $ 38,702.91 |
| Council Expense | | 16,851.05 |
| American Medical Association Meetings Expense | | 9,151.36 |
| State Meeting Expense | | 19,343.90 |
| Legal and General Counsel Expense | | 1,000.00 |
| Journal Expense | | 85,777.18 |
| State Fair Exhibit | | 889.02 |
| Chicago Medical Society—Services | | 712.10 |
| Committee Expenses: | | |
| Advisory—I. P. A. C. | $ 116.08 | |
| Advisory—Occupational Therapy Assn. | 33.23 | |
| Advisory—United Mine Workers | 226.67 | |
| Archives and Medical History | 7,044.14 | |
| Cancer Control | 110.46 | |
| Educational | 11,734.56 | |
| Ethical Relations | 10.00 | |
| Fifty Year Club | 220.06 | |
| Illinois Joint Commission for Improvement of Care of Patients | 204.96 | |
| Industrial Health | 187.88 | |
| Interprofessional Relations | 511.66 | |
| Liaison Committee on Medical Education | 49.85 | |
| Liaison Committee—American Legion | 173.12 | |
| Maternal Welfare | 831.51 | |
| Medical Service and Public Relations | 31,387.48 | |
| Medical Testimony | 60.55 | |
| Medico-Legal | 20.00 | |
| Mental Health | 74.48 | |
| Military Affairs and Emergency Medical Service | 8.35 | |
| Nursing | 136.50 | |
| Nutrition | 1,275.94 | |
| Polio Control | 126.62 | |
| Postgraduate | 4,084.13 | |
| Scientific Service | 602.65 | |
| Secretaries' Conference | 1,263.71 | |
| Tuberculosis | 132.23 | |
| Woman's Auxiliary | 2,262.55 | 62,889.37 |
| Chicago Office Expense (Undistributed) | | 23,314.26 |
| Social Security Taxes | | 923.73 |
| State Unemployment Insurance | | 89.09 |
| Federal Unemployment Insurance | | 99.39 |
| Blue Cross-Blue Shield | | 106.00 |
| Rural Medical Service— Deposit to Student Loan Fund, Ill. Agricultural Assn.—Ill. State Medical Society (Trust Fund #37363) | | 10,000.00 |
| Transfers: | | |
| Benevolence Fund | $ 18,928.00 | |
| American Medical Educational Foundation | 189,310.00 | |
| American Medical Association Dues | 236,462.50 | 444,700.50 |
| Total Payments | | $714,549.86 |
| Cash Balance April 30, 1956 | | 244,177.94 |
| Total | | $958,727.80 |

FRED N. SETTERDAHL
CERTIFIED PUBLIC ACCOUNTANT
224 Robinson Bldg. Rock Island, Illinois

CERTIFICATE OF AUDIT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:
ILLINOIS STATE MEDICAL SOCIETY.

We have audited the following accounts of your Society for the fiscal year ended April 30, 1956:

Secretary's Office—Dr. H. M. Camp, Secretary
Journal Office—Mr. L. E. Malley, Manager
Educational Committee—Miss Ann Fox, Secy.
Benevolence Fund—Dr. H. M. Camp, Secretary
Chicago Office Accounts

Dues received from Component Societies have been verified with duplicate receipts, the master ledger cards of each Component Society, and were compared with the Secretary's report.

The receipts include amounts received for the Benevolence Fund, A. M. A. Dues, and the American Medical Education Foundation, which have been transferred or remitted to the respective funds.

Journal Advertising receipts have been verified with the records of the Journal Manager who receives and remits same to your Secretary.

Bond interest received for the General Fund and Benevolence Fund was compared with interest due on Government Bonds.

Other receipts consist of Exhibit Rentals, Journal Subscriptions, Refunds, etc., which have been taken into account as recorded. All receipts are recorded by the Secretary and are deposited in the name of the Society in the depository bank.

Payments were made by check and were supported by approved vouchers.

The cash balances have been reconciled with the amount on deposit, as shown by the statements of the depository banks.

Investments of the General Fund consist of U. S. Bonds with a par value of $90,000.00 and 31 and 70/100 shares of common stock of the Chicago and Northwestern Railway Company. These shares have a market value of about $850.00 and were issued in lieu of bonds formerly held.

Investments of the Benevolence Fund consist of U. S. Bonds with par value of $140,000.00 All securities held were inspected by us and are issued in the name of the Society.

There is a cash balance of $57,702.82 in the Benevolence Fund.

The accounts of the various departments have all been well kept and, in our opinion, your Secretary's Financial Report presents the cash transactions for the year.

The Council will be furnished with a detailed audit report, which agrees in totals with your Secretary's report.

Respectfully submitted,

FRED N. SETTERDAHL,
*Certified Public Accountant*

May 1, 1956

## THE CHAIRMAN OF THE COUNCIL

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The report of the Chairman of the Council will be brief and concise in conformity with the trend toward brevity of annual reports this year.

As usual the volume of business going through the Council has been very heavy this year. Regular meetings of the Council have been held in June, August, October, December, January, March and April. There have been no special meetings. Attendance of the Councilors has been excellent and they are to be congratulated for their sincere efforts. I want to particularly congratulate the members of the Executive Committee for their perfect attendance and for their willingness to participate in all matters brought before them. This Executive Committee meets each Saturday night before the Council meeting on the following day and tries to bring these matters before the Council in a clear and concise manner. The volume of work passing through this Committee is tremendous, and your Chairman appreciates their faithful service and one hundred per cent attendance at every meeting which has been held.

The various Committees of the Council have functioned well during the last year; the volume of work done by the Committee on Medical Service and Public Relations, the Educational Committee, the Postgraduate Committee, and Scientific Service Committee has been particularly heavy and the Chairman wants to congratulate them on a task well done. The Advisory Committee to the Auxiliary and the Journal Committee and the Educational Committee have also done a most commendable assignment. The Advisory Committee to the Illinois Public Aid Commission has worked long and arduously for the benefit of the Medical Profession of Illinois. The Committee on Medical Benevolence, under a new Chairman this year, has appeared before the Council on several occasions and has, I am sure, impressed the Council with their zeal and business-like attitude toward a very difficult phase of our Medical organization. The Committee on Nursing has been particularly active and the Chairman, Dr. Maurice Hoeltgen, has attended every meeting of the Council and has impressed that body with his awareness of a most difficult situation in our state. The various other Committees, while not having such a large volume of business, have discharged their obligations faithfully, and the Chairman appreciates their efforts. Your Chairman should like also, to direct your attention to the great volume of work done by the Secretary, Dr. Camp, to the untiring efforts of Mrs. Frances Zimmer, the executive assistant to the Secretary, to the force in the Monmouth office, and to the entire force in the Chicago office.

The number of Council Committees is very numerous and an effort has been made this year to consolidate some of them whose interests would seem to be parallel. Since considerable thought and effort has been made toward this during the Council year the Chairman reserves the right to present a supplementary report to the House of Delegates if a solution has been reached by the time of the annual meeting. Your Chairman would like to call to the attention of the House of Delegates the possibility of a change in time for the annual meeting of the Society. Much informal discussion has been going on regarding this subject and if some definite recommendation is made by the Council before the Annual Meeting the Chairman will also present this as a supplementary report.

The Chairman is ending his tenure of office this year. During the past two years it has been a privilege to have served as Chairman of the Council. The courtesy and understanding which have been extended to the Chairman is more appreciated than words can convey. It has indeed been a privilege and honor to have been the recipient of this high office.

Respectfully submitted,

JOSEPH T. O'NEILL, M. D.
*Chairman of the Council.*

DR. O'NEILL: Mr. President and Members of the House of Delegates: The Council asked me to present this resolution as a supplementary report. It was referred to the House of Delegates at the meeting of the Council this morning.

WHEREAS, the Council of the Illinois State Medical Society has felt that the annual meeting of the Society is an important event which should attract a large registration, and

WHEREAS, the Council feels that although every medium possible has been used to attract such a large registration,

THEREFORE BE IT RESOLVED, that the House of Delegates here assembled at the 1956 annual meeting direct and request the Council to explore by whatever means the Council sees fit the possibility of changing the time of the annual meeting to the fall of the year instead of May, and that the Council take whatever steps are necessary, if in the judgment of the Council this seems desirable.

THE PRESIDENT: You have heard this report. It will be referred to the Reference Committee on Reports of Officers, Dr. A. J. Mauzey, Chairman.

## REPORTS OF COUNCILORS

### FIRST DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The First District is one that divides itself into two rather distinct groups.

Winnebago County is large and well organized, with a full time executive secretary. Their administration functions well and their problems are expertly controlled by this central organization. This county and two other large groups near Chicago feel they would rather attend meetings in Chicago, than to promote the post graduate meetings within their own area. These counties have a well planned and executed public relations program with excellent newspaper and radio coverage.

The smaller counties, being too small to independently support post graduate ventures, have not seen fit to combine with neighboring counties. Their public relations are on a much smaller scale but adequately handled. Several grievance problems have arisen in the smaller counties, and this office has been able to help resolve them to the satisfaction of everyone concerned.

It has been my pleasure to present several 50 year club emblems to worthy members in the district this year.

Respectfully submitted,
CARL E. CLARK, M. D., *Councilor, First District.*

## SECOND DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The past year in the Second Councilor District of Illinois has been quite uneventful. The affairs of each County Society are in capable hands and each component County Society is functioning well. The Councilor will have visited each of them by the time of the annual Meeting. In addition to being Chairman of the Council this year the Councilor has been a member of the Journal Committee and the Educational Committee.

The one situation which confronts us in the Second District is the situation in which we find all of our hospitals so under-staffed as far as nursing personnel is concerned. The last school of nursing in the District has been closed. at least temporarily. Some hope for its revival is being considered at the present time. Your Councilor feels that an expression of gratitude and appreciation should be expressed to the Illinois Agricultural Association for their valiant efforts in calling attention to the proper authorities the critical situation in regard to nurses which exists in our district, and indeed throughout the whole state. It is hoped that some practical solution will be found to alleviate this shortage. Your Councilor wants to thank the officers of the various County Societies for their extreme courtesy and cooperation with him during the past year. It has been a pleasure to have served them during the year.

Respectfully submitted.
JOSEPH T. O'NEILL, M. D.
*Councilor, Second District.*

## THIRD DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Chicago Medical Society is composed of 15 branch groups and is affiliated with 23 specialty groups. Every effort is made to keep its membership abreast of modern advancements in medical science.

New activities are constantly being added and the regular program featured in past years has been extended. The prestige of the Society has been more firmly established by such activities as the Clinical Conference and the Postgraduate Courses.

### DOCTORS EMERGENCY SERVICE

The Doctors Emergency Service in 1955 took care of 4.168 emergency calls. Recently the service embarked on a rather extensive publicity campaign in order to bring to the people of Chicago solicitation of their home medical care. There is a continual increase of demand for this service and up to date we have been able to service over 95% of the calls. If the demands increase for this medical service Chicago will surpass New York.

The participating physicians on this panel are doing a wonderful job not only in saving lives but in the promotion of good public relations.

### GRIEVANCE COMMITTEE

The Grievance Committee of the Chicago Medical Society handled 249 complaints in the past year. Most of the complaints were due to misunderstanding and were settled without the necessity of calling in the doctor and complainant. In some cases the Committee recommended an adjustment in fees and a friendly settlement was reached. Five doctors were called in and five complainants and the cases were settled satisfactorily. A few cases required additional investigation. Four doctors were referred to the Committee to Investigate and Consider Informal Charges of Unethical Conduct. A very small proportion of the number of complaints recieved represents justifiable grievances against physicians.

### EMERGENCY MEDICAL SERVICE

A small number of Radiological Monitoring Instruments have been received by the Chicago Civil Defense Corps and are being distributed to the proper personnel. Training courses for monitors are being developed.

Training courses in medical radio communications are being developed since the arrival of a small number of "walkie talkie" type radios by the Chicago Civil Defense Corps.

There has been no further implementation of the First Aid Station and Emergency Hospital Plan this year. One civil defense emergency hospital was offered to the Chicago Civil Defense Corps in November 1955 on loan from FCDA for demonstration, educational and training purposes. It is hoped that the Chicago Civil Defense Corp will shortly complete negotiations for its acceptance.

The Metropolitan Chicago portion of the National Survival Study Projects will shortly get under way.

The over-all functional picture of the Health Services Division of the Chicago Civil Defense Corps has not improved appreciably in the past year. It is the contention of the Committee on Emergency Medical Service that it is futile to attempt to organize and train health services personnel without pertinent equipment.

### COMMITTEE TO INVESTIGATE AND CONSIDER INFORMAL CHARGES OF UNETHICAL CONDUCT

The Committee has been very active throughout the year and has considered all the cases which were brought before it.

Although a goodly number of cases were processed, the Committee is pleased to report that the large majority were settled without recommendation for further consideration by the Ethical Relations Committee.

### ETHICAL RELATIONS COMMITTEE

The Ethical Relations Committee has been active and has met problems as they were presented. There have been a number of inquiries about advertising, etc., which is a good indication that the physicians are aware of the Ethical Relations Committee and their work. We are happy to see that the physicians are cognizant of their responsibility to maintain the high standards of ethics of the medical profession.

### THE CLINICAL CONFERENCE

The Annual Clinical Conference of the Chicago Medical Society was held February 28th and 29th and March 1st and 2nd, 1956. Despite the competition of other nearby medical meetings of high caliber the registration totaled 6413 including guests and senior medical students. The speakers represented a cross section of foremost medical educators and the physicians of the midwest responded in splendid fashion. In addition to the Chicago physicians present, the greatest attendance was by Illinois doctors although our medical neighbors were there in goodly numbers. The spirit of the meeting coupled with favorable weather justified the Conference slogan: Four Intensive Postgraduate Days in a Great Medical Center.

### PRESS RELATIONS

The Press Relations Committee is frequently called upon to give advice in connection with the proposed appearance of members of the Society on television, radio or before public assemblies. Members of the Committee have tried to point out on such occasions that there is no objection to an individual making such an appearance and that the responsibility for his conduct rests entirely with himself. Members of the medical profession in this area have been on the whole quite cooperative in this matter. Valuable and educational information can be presented without any suggestion of advertising or publicity on the part of the individual.

The Committee is cognizant of the fact that if

accurate health information is to be given to the public the source of such information should be members of the medical profession. Occasionally a news editor is still encountered who seems to take exception to some of the tenets of the code of ethics, but such instances are few and far between. In general, a good relationship exists between the members of the press and the medical profession in this district.

### Tuberculosis Control Committee

This is the eleventh year of the Tuberculosis Control Committee and its achievements during the past year include:

1. Legislation was passed enlarging the Municipal Tuberculosis Sanitarium Board from three to five members. Dr. Frank Fowler, past President of the Chicago Medical Society, was appointed a member by Mayor Richard Daley.
2. The Committee aided in the passage of the regulation making it mandatory that food handlers have a yearly chest x-ray.
3. The Committee supported the school personnel x-ray State Legislation Program which requires all teachers and school personnel to have a yearly chest x-ray.
4. The combined case-finding programs of the Municipal Tuberculosis Sanitarium, the Suburban Cook County Tuberculosis Sanitarium District and the Tuberculosis Institute of Chicago and Cook County this year took more than one million survey x-rays of the Cook County population.
5. The Committee has consistently urged hospitals to take hospital admission x-rays. Additional hospitals are providing such facilities.
6. Despite the fact that tuberculosis deaths are dropping rapidly, tuberculosis still constitutes the Number One public health problem in the Chicago area. The total number of new cases reported consistently remains high and the Committee urges total support of all tuberculosis control measures.

### Child Health

The Child Health Committee continues to give medical direction to the Chicago School Health Program. The program is developing normally along the lines outlined in previous reports. The role of the medical society is a sound and well-delineated one. It gives the local physician an important position in the area of school health, and it illustrates the importance of broad based planning and a clear allocation of responsibility in a multi-agency health program such as this one. The "Chicago Plan" is being copied more and more throughout the country.

### The Health and Accident Insurance Program of The Chicago Medical Society

The group health and accident insurance program became effective December 1, 1953. The initial participation of the members was about 55%. This rate has increased to well over 60% at present. The health and accident program allows a choice of 7 day, 30 day, or 6 months waiting period. The carrier is the Lumberman's Mutual Casualty Company of Chicago. Mr. C. O. Finley is the administrator. The plan has operated satisfactorily for the subscribers. The loss ratio has remained within the expected pattern. The adjudication Committee has had occasion to meet only at infrequent intervals during the year. It appears that all problems or differences have been resolved satisfactorily. All enrollments and advertising is supervised by the Committee on Insurance of the Chicago Medical Society.

### Committee on Insurance

Enrollment in the term life insurance program (developed especially for the younger members) was opened last October 1955 and was closed in April 1956. The carrier was the Minnesota Mutual Life Insurance Company. The administrator was Mr. Wm. D. Davidson and Mr. E. Rigdon Robb of Medico-Insurance Planning Inc. By January enough applications (under the age of 40) were received to fulfill the requirements for a group unit which waived evidence of insurability. It is probable that other age groups will be established. (This requires 50% participation.) The original request was for $10,000 term life insurance for younger members but because older members were interested, the enrollment was opened to all under age 65 years. The term life plan converts automatically in 10 years or at age 65 years if sooner. In the event of disability, premiums are waived. The premiums average 35% lower than those for similar coverage in the ten largest mutual companies. New members of the society may be enrolled by age groups without evidence of insurability. The promotion and advertising and enrollment was under the supervision of the Committee on Insurance.

### Professional Liability Insurance

The Committee on Insurance continued its study of a number of local and state plans and the reasons for them. Representatives of the Committee visited the Northern California and the Los Angeles areas and the New York State Medical Society Committee. Individuals of the Committee have obtained information about other plans and their problems. The desires of the members of the Chicago Medical Society are being determined.

### Blue Shield and Blue Cross

The Blue Shield Plan of Illinois Medical Service with headquarters in Chicago paid a total of $9,836,672.46 to physicians for a total of 212,583 services during the year 1955. This marked a new record high in payments to physicians in any year by this Blue Shield Plan and brought total benefits paid by this Plan to physicians to $33,001,973.46 since its inception.

Late in 1955, this Blue Shield Plan offered a new certificate—known as Series "C"—which will provide many substantially increased allowances over those which have been offered in the past by the General Certificate. This Series "C" Certificate is in addition to—but does not supplant—the General Blue Shield Certificate. This new Series "C" Plan will be offered in answer to a public demand from certain groups who desire a higher schedule for payments to physicians. Members, of course, pay higher dues for Series "C" membership than they do for the General Certificate.

Another forward step was the offering (jointly with Blue Cross) of a non-group enrollment during a two week period in April, 1956—which gave people under 65 and in good health an opportunity to join on an individual basis.

Another recent accomplishment is the development of a special Extended Benefits program which will provide up to 2 years of special allowances for in-hospital medical care for each different and unrelated illness or accident. This is also a joint offering with Blue Cross.

The Blue Cross Plan of Hospital Service Corporation with headquarters in Chicago—which is offered as a companion Plan to Blue Shield of Illinois Medical Service—had 2,243,803 members as of December 31, 1955—and paid out a total of $44,622,941.92 for the care of members during the year.

Days of benefits were increased for Comprehensive and Cooperative members from 30 full and 90 half days each calendar year to 120 full days of benefits per illness or accident. These benefits also were made available in more than 6,000 Blue Cross hospitals throughout the United States and Canada and in recognized hospitals abroad—in addition to the 228 member hospitals of this Blue Cross Plan in Illinois.

During the year Blue Cross crossed the 50 million membership mark nationally — and this Plan is now one of the four largest Plans in the country.

### Postgraduate Courses

The Committe is very pleased to report the success of the two postgraduate courses which were given

by the Chicago Medical Society.

A course in Basic Principles and Recent Developments in Pediatrics was held October 17 to 21 and one in Basic Principles and Recent Developments in Obstetrics and Gynecology was held October 24 to 28, 1955. These courses were held in the Knickerbocker Hotel.

It has been very gratifying to note the number of applicants registering for these courses. Physicians from all parts of the country attended. Many physicians return each year.

Abstracts of all papers in book form were furnished to all those attending. These have proved to be very helpful and so much in demand that the practice will be continued in subsequent courses.

All participating physicians were asked to fill in a questionnaire regarding their general reaction to the courses. Based on the completed questionnaires and the comments of those in attendance it is evident that the courses are well received and of genuine benefit to the students.

The postgraduate courses this fall will again be held at the Knickerbocker Hotel. "Modern Therapeutics" will be given October 29 to November 2 and "Practical Aspects of Endocrinology" on November 5 to November 9. We are anticipating that many physicians will avail themselves of the opportunity to attend these courses.

PUBLIC RELATIONS COMMITTEE

The public relations activities of a large medical center require a great diversity of attention. The interest ranges from the organization of certain standards for groups or "clinics" and the measured restraint of those parading as such to the location and moving of monument of medical interest and the participation with large civic groups interested in Health Fairs. A very casual survey reveals a great tendency to play upon the name "Medical Clinic". Some of these are promoted by architects or builders, some by physicians desirous of capitalizing on public credulity. Regulations have now been accepted regulating the use of signs denoting clinics in an attempt to assure the public that proper medical facilities are available and that such signs are not merely advertising devices. A recent project has called attention to the "Guthrie" stone, a large boulder donated by the Chicago Medical Society, dedicated to Samuel Guthrie, M. D. (1782-1848) who discovered a way to produce chloroform and adapt it to anesthesia purposes. This stone is now in Jackson Park but it is thought a more fitting place would be the new park between Cook County Hospital and the Congress Street expressway.

WOMAN'S AUXILIARY ACTIVITIES

The Woman's Auxiliary to the Chicago Medical Society has just completed its Twenty-Eighth year of service and health education. It has proved to be one of achievement, progress and continuity for our auxiliary.

At present the membership is 987, but we anticipate over 1000 with the completed organization of an auxiliary to the South Side Branch of the Chicago Medical Society. We shall then have a total of fourteen, one to each branch medical society, except one.

The program of Public Relations has been outstanding through the combined efforts of County and branch auxiliaries. Speaker for the November meeting was Dr. Elmer Hess, President of the American Medical Association, whose topic was "Public Service Means Personal Sacrifice". He spoke to an audience of over 500, with over 100 Civic and Community Organizations represented as County guests. A program demonstrating the use of "Music Therapy" in the treatment of mental and physically handicapped was presented by an orchestra and chorus of forty patients from Downey Veteran's Hospital in March. The play, "45 Minutes-Or-Eternity", was presented by auxiliary members at the Conference of County Medical Society Civil Defense Chairmen in the fall. In addition programs have been given on Cancer, Heart, Mental Health, Safe Reducing, Nursing, Legislation, A. M. E. F., Auxiliary Makeup, Juvenile Delinquency, the Changing Medical Scene.

At the Clinical Conference of the Chicago Medical Society, a Hospitality Room was maintained with 537 women registering. Fashion Show and Luncheon was attended by 605 Doctors' wives.

Through the generosity of the Board of Trustees of the Chicago Medical Society, 4000 subscriptions to the Bulletin of the Woman's Auxiliary to the American Medical Association were credited to the auxiliary. Subscriptions to Today's Health total 552 (2/12) to date. Over $2,000.00 is available for Nursing Scholarships in addition to two Future Nurses Clubs. Branch donations to the Benevolence Fund are not complete at this time but $1,500.00 has been contributed. The A. M. E. F. has been supported by $2,500.00. Members will participate in the 80 Dimes Campaign during Medical Education Week. The sale of the History of Medicine in Illinois has been stressed at each meeting. We feel we have exemplified, by our efforts and achievements, our theme, "United We Shall Progress for Better Health".

VETERANS SERVICE COMMITTEE

The chief concern of the Veterans Service Committee is to see that the veteran and the future veteran are dealt with on an equal basis. It attempts to learn of any who are evading service. Returning veterans of recent years, as well as the older veterans, are all proud of a job well done, but do not enjoy having done that job while many hide behind a subterfuge and do not serve. Particularly has this been the case with many of our foreign graduates. This Committee has attempted to bring these facts before the medical society this past year.

The controversy between the American Medical Association and the American Legion regarding hospitalization of all veterans has been observed from a distance with only slight activity on the part of this committee.

Respectfully submitted,
R. C. Oldfield, M. D.
John Lester Reichert, M. D.
Earl H. Blair, M. D.
H. Close Hesseltine, M. D.
E. A. Piszczek, M. D.
Caesar Portes, M. D.
*Councilors, Third District*

## FOURTH DISTRICT

To the Members of The House of Delegates:

Affairs in the Fourth District have been very ordinary for the most part during the past year. No particular difficulties have arisen that needed more than consideration in the local County Society.

Perhaps the most perplexing problem confronting the members in some of the societies concerned Polio vaccine. This, of course resulted from the fact that the Physicians had not read their mail, else there would have been no problem. This item required explanation by telephone, on the part of the Councilor. However it is now most happily settled by the increased supply.

It is the opinion of this Councilor that the individual physicians in this district have, either intentionally or by reason of the "trend" become much more concious of the personal contact with the patient as a matter of public relations, as well as that of being a therapeutist. Another omen predicting a more amicable relationship among members, especially in smaller societies, is their acceptance of the principles involved in the establishment of their grievance committees. And may we add a mite to the suggestion that itemized bills if put in general use might obviate a large percent of grievances. There are a few men

in this district who already practice this.

More meetings, specialty societies, Hospital Staff meetings, Post Graduate meetings, etc. etc., have tended to lessen, or lower the station of the County Society meeting. But the counties in this district have maintained their regular meetings and the quality of the programs have been the highest. Practically each of our local societies has held regular scheduled meetings. More of these units have availed themselves of the services of our scientific service committee.

A most interesting and instructive post-graduate conference was held for our district at Monmouth. This meeting was attended well and many Physicians expressed the desire that such meetings might be continued. The Dentists and Pharmacists of Monmouth were guests at the Dinner and at the evening program.

Your councilor has presented 50 year certificates and buttons to the men eligible for membership in the 50 year club. A few more than usual in a year have been honored this last year.

This councilor has attended all meetings of the council, and has served as Chairman for the Educational committee, and as a member of the advisory committee to the I. P. A. C.

The year's work has been very interesting and our association with other councilors has been instructive and most enjoyable. We have had most excellent support in every way from the officers and members of the local societies.

Respectfully submitted,
CHARLES P. BLAIR, M. D.

## FIFTH DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The past year has presented no unusual problems in the Fifth Councilar District. The component county societies have held regular meetings and excellent scientific programs have been presented. One disturbing factor, however, has been the ever present and constantly recurring problem of a comparatively small percentage of the membership attending meetings. While this may be viewed from one aspect as approval and satisfaction with the way in which the officers are conducting the business matters of the society, such indifference and complacency is a perilous situation with so many adverse factors seeking to disrupt a unified medical front.

The members of this District were saddened to hear of the death of Dr. Ralph P. Peairs, Normal, Illinois, on December 18, 1955. Doctor Peairs had served as Councilor of this District for 15 years, retiring in 1952.

As in past years, a number of the State Society's activities have centered in Springfield. Two major events have been the exhibit at the Illinois State Fair and the Secretaries' Conference. The former has been more fully developed and attracted more attention each year. This project, instituted seven years ago on a local basis by the Auxiliary to the Sangamon County Medical Society, has received recognition and support of the State Society for several years. The staffing and management of the booth, however, has continued to remain as one of the Auxiliary's annual projects. Thousands of Fair visitors inspected three exhibits and viewed five medical movies as well as receiving pamphlets and sample copies of "Today's Health" provided by the AMA. Attracting the greatest attention was the exhibit "See The Medicine Show," which detailed many past and current quackeries and medical frauds. At the exhibit the public's attention was also called to a newly established 24-hour Emergency Poisoning Center at one of the Springfield hospitals.

The annual Secretaries' Conference met on March 25 at the Leland Hotel in Springfield with an attendance of 94. The conference officers, headed by Dr. William DeHollander, are to be commended for an unusually interesting and attractive program of practical subjects of importance to county medical society officers. The conference voted to request permission to hold the 1957 meeting in Springfield.

Morgan and Sangamon County Medical Societies jointly sponsored a Postgraduate Conference honoring President Garm Norbury in Jacksonville March 22. No other postgraduate conferences were held in this District because of the nearness of other postgraduate conferences, the multiplicity of medical meetings and conflicting dates.

The medical profession's readiness to render sick care and emergency service was called to the public's attention at a Jaycee sponsored "Health Fair" April 4-5 in Springfield. One of the 33 exhibits exemplifying the theme "Let's Do More About Health" was the Sangamon County Medical Society's booth citing the availability of physicians on a 24-hour emergency care and call service.

During the past year I have attended all meetings of the Council and several Postgraduate Conferences. In addition, I have served as chairman of the Illinois Medical Journal Committee and as a member of the Editorial Board, the Liaison Committee on Medical Education, Veterans' Medical Affairs Committee, Constitution and By-Laws Committee, Voluntary Prepayment Plans for Medical and Surgical Care Committee, and the Postgraduate Educational Committee. Also, some Committee meetings and sessions of the House of Delegates of the AMA Annual Meeting in Atlantic City were attended.

It has been an honor to serve as the Fifth District Councilor and I gratefully acknowledge the cooperation and assistance of the officers and members of the county societies of this District. To have been re-elected by the 1955 House of Delegates proffered both an honor and a new obligation. This responsibility I shall strive to fulfill in a sincere and efficient manner.

Respectfully submitted,
JACOB E. REISCH, M. D. *Councilor, Fifth District*

## SIXTH DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The medical affairs of the Sixth Councilor District have apparently been going along smoothly, although there continues to be some apparent dissatisfaction in certain localities with the I. P. A. C.

All of the Counties holding regular meetings have been visited or will be visited before the annual meeting in May.

A postgraduate meeting was held in Jacksonville on March 22, 1956. The meeting was in Co-operation with the Fifth Councilor District. The attendance at this meeting was somewhat of a disappointment in as much as it did involve two Councilor Districts, however the program put on by the Stritch School of Medicine was excellent which held the attention of the audience throughout the afternoon. No arrangements had been made for entertainment for the ladies, which was rather embarrassing, so in the future some arrangement must be made to take care of the visiting ladies to these postgraduate meetings. Pittsfield has put in a request for a postgraduate meeting next fall and Carlinville is likewise expected to have one.

Fifty year club certificates and emblems were presented to Dr. Jones of Winchester, Dr. Brewster of Jerseyville and Dr. Giberson of Alton, Dr. Hamm of Granite City. These meetings were all very well attended.

Respectfully submitted,
W. H. NEWCOMB, M. D., *Councilor, Sixth District.*

## SEVENTH DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The constituent societies of the Seventh Councilor District have had a few problems during the past year and the spirit of cooperation has been excellent.

The Post Graduate Conferences have been thoroughly appreciated. There have been three given up to the time of this report, the fourth to be held in April. The sessions were most informative, conducted by high caliber personnel, for which the Post Graduate Medical Education Committee is to be commended. The programs were: First, Vandalia, October 20, 1955 at the beautiful new Fayette County Hospital, by the Hines Hospital Staff. Second, Taylorville, November 10, 1955 by the University of Illinois Faculty. The speaker of the evening was Dr. LeRoy Sloan, Clinical Professor of Medicine, University of Illinois Medical School and Past President of the American College of Physicians. Third,—Effingham, March 7, 1956 given by Henrotin Hospital Staff, Dr. F. Lee Stone, President-Elect of the Illinois State Medical Society was the speaker of the evening. The Effingham County Medical Society Auxiliary provided a delightful luncheon and program of entertainment for the visiting wives attending the Effingham Post Graduate Conference. Attendance at all of the sessions was excellent. The Taylorville meeting no doubt, would have been larger had there not been an unpreventable conflict with a Public Relations Meeting held in Decatur on the same date.

Two Fifty Year Certificate awards were made. The first presentation was to Dr. Arthur C. Whiteford of St. Elmo at a special meeting of the Fayette County Medical Society at the Fayette County Hospital in May. One week later the civic organizations of St. Elmo, headed by the Lions Club, gave a testimonial banquet at the Community High School, followed by a general community evening program in the High School gymnasium. Approximately 1500 persons attended Six Fifty Year Club doctors from the surrounding countryside were present to pay tribute to Dr. Whiteford, including the perennial President of the Fifty Year Club, Dr. Andy Hall.

The second 50 year recipient was Dr. C. Roy Johnston of Decatur. This award was presented preceding the Macon County Medical Society Scientific meeting in May at the Decatur Club. Dr. Johnston's classmate, Dr. Arthur C. Whiteford, assisted in the ceremony.

The awarding of the Fifty Year Certificates continues to be one of the most pleasant duties of this Councilor.

The Womens' Auxiliaries are showing rapid growth and assuming many responsibilities. Medical Benevolence heads the program of major projects. They have now been given the task of campaigning for the "Eighty Dimes Fund" for the American Medical Education Foundation, which they have graciously consented to give their best efforts.

On December 13, 1955 your Councilor was requested to attend a meeting of the Christian County Medical Society in Pana in order to hear a resolution protesting the arbitrary action of the United Mine Workers Welfare Fund Director. The directive stated that all surgery in the future, would be performed by surgeons certified by the American Board of Surgery and the American College of Surgeons. The resolution protesting this directive will be presented at the meeting of the House of Delegates of the Illinois State Medical Society at the Annual Meeting in May 1956.

Public Relations continue to be enhanced by active grievance committees.

Voluntary Insurance programs are progressing rapidly. Blue Cross and Blue Shield being most prominent in the field.

Macon County is to be congratulated on the organization of a Mental Health Clinic which has been approved by the Macon County Medical Society.

Your Councilor takes this opportunity to thank each County Society and their Auxiliaries in the Seventh District for courteous and friendly assistance this past year, and is looking forward to 1956-57 with pleasant anticipation of continued progress.

Respectfully submitted,

ARTHUR F. GOODYEAR, M. D., *Councilor, Seventh District.*

## EIGHTH DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

1955 and 1956 have been very successful years from the medical standpoint in the Eighth District. Our post-graduate conferences have been well attended. All troublesome matters between doctors and patients have been resolved without litigation.

The Health Improvement Association in the Eighth District has been increasing its membership numerically and with the increased numbers of farm folks enrolled in H. I. A. the financial aspect has improved.

In Danville, Illinois, a successful campaign to raise a million and a half dollars is about to be concluded. This will add additional new rooms and renovate some non-fireproof hospital beds present in that city.

There has been much worry and real concern about the future of our nurses training schools in the Eighth District. Continuing pressure for upgrading and for following the League of Nursing Education's pattern is causing great worry about the future care of the sick in our area. We are looking hopefully toward the April 12 conference in Springfield to see if other parts of the state have arrived at the proper answer to this desperately serious problem.

Despite all hope to the contrary, the number of people on the Public Assistance roll is continuing to be about the same, and the drain on the taxpayers is proportionately very high. No one seems to know the answer to this continuing pattern of state and federal financing of the care of so many of our citizens.

Respectfully submitted,

HARLAN ENGLISH, M. D., *Councilor, Eighth District*

## NINTH DISTRICT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The past year has brought two particular problems to the Doctors of the Ninth District.

1. The Directive November 1, 1955 of the U. M. W. A. in which it is stated that the Fund will pay only Board, Board eligible or F. A. C. S. surgeons for the surgical care of U. M. W. A. patients.

2. The ever increasing problems of the care of I P A C patients.

With reference to the first problem, the council of the Illinois State Medical Society has sent a resolution to the A M A, protesting the above directive. We have no indication at the present time as to when an opinion will be given.

With reference to the problems of the I P A C, will say that the State Medical Advisory Committee has been very active in trying to arrive at solutions to these problems and this will be covered in the report of this Committee.

There have been four 50 year certificates presented to Members of the State Society in the past year. A very fine meeting was held in Mt. Carmel to honor the 50 year men and Dr. Andy Hall was delegated to make the presentation speech. He did a very fine job as always.

The past year has brought no great problems aside from the above mentioned. There have been no ethical problems or problems for the grievance Committees.

There have been no Post Graduate Programs in the 9th District the past year, but we hope to have at least two this coming year.

Your Councilor wished to express his appreciation for the continuing fine co-operation of the Doctors and Medical Societies of the Ninth District.

He also wishes to express his gratitude to the Council and officers of the Illinois State Medical Society

for their help and friendship during the past year.

Respectfully submitted,

B. E. Montgomery, M. D., *Councilor, Ninth District.*

## TENTH DISTRICT

To the Members of the House of Delegates:

We are again closing another fiscal year of the Illinois State Medical Society. We have encountered a few controversies and perhaps, we have seen some handwriting on the wall. Other problems that we have been confronted with are repeat stories of previous years.

The problems of the Illinois Public Aid Commission are always with us and it seems as though the attitude of the Illinois Public Aid Commission is a little more in opposition with medicines' ideology than ever before. Their line of reasoning is a little difficult for the medical profession to accept completely. However, we have to deal with them and we do have some argument in as much as their funds are tax supported and some curtailment of activity of course is necessary, and as much as possible we have been given the same prerogative as always to do our own policing.

The United Mine Workers Welfare and Retirement Fund issued a memorandum on November 1; The sum and substance of which will be given in the report of the Advisory Committee to the United Mine Workers and the exact report of that committee does not need repetition in the councilor report. However, there are a few things that perhaps should be mentioned in passing concerning their program or their proposed program. There seems to be a trend, or at least an attempt for the control of the doctor's patients to be taken away from the doctor when a third party is involved. It is particularly manifested in the present attitude of the proposed program of the United Mine Workers. It seems as though there is: First, a definite trend to increase the importance of specialists and second, to remove the private physician from the control and supervision of his own patients. The third party in a medical situation can be most helpful to the financial stability of the patient, but it can also be a financial catastrophe to some doctors, and to other doctors it can easily become a distasteful nuisance. It is hoped that unpleasantness in dealing with third parties can be avoided and that the general satisfaction for the majority can be achieved. We have found in our dealings with the United Mine Workers that the origin of complaints against doctors by the management of the fund is not entirely without provocation. There have been some cited incidences in which some doctors and some hospitals have been completely out of line, especially in the amount of fees and bills, and where prolonged care was involved, which should have been avoided. Some of the fault may be due to the Fund itself, but certainly a certain amount of the fault was due to the negligence of the hospital or the physician in charge in not notifying the Fund that a patient was hospitalized for an unusually long time and apparently sometimes getting inadequate treatment.

There will be, by the time the House of Delegates meet, two Postgraduate Conferences of the major type held within the Tenth District. One was held at Anna in November and one in Belleville on April 5. The attendance at the Anna meeting unfortunately was not too good; however, the program was an excellent one. The program was consummated with the presentation of two fifty year pins and certificates: One to Dr. Charles D. Nobles of Anna, and one to Dr. James R. Tweedy of Cobden. One had been presented to Dr. Otto W. Knewitz of East St. Louis earlier in the year.

I wish to take this opportunity to thank all the officers and delegates of the Tenth Councilor District for their kindness and helpfulness during the past year. I look forward to the next year for continued support and work for medical organization and medical unity. We must strive to keep in contact with our legislators; keep up proper public relations, remembering always that the best public relations begins first in the doctor's own office. This is election year. Let us all be positive that we are eligible to vote and mark it down in our calendars to vote at each and every election. This indeed may be a year of decision. Probably every year is a year of decision, but this may be a year which will mark the beginning of an era under which we must be prepared to take our stand.

Respectfully submitted,

Willard W. Fullerton, M. D., *Councilor, Tenth District.*

## ELEVENTH DISTRICT

To the Members of the House of Delegates:

The report from the Eleventh Councilor District is most satisfactory and encouraging. All the Component County Societies are active and growing in size. All are holding regular meetings and the interest of the members is high.

The annual Postgraduate Conference for the year was held at Elmhurst in DuPage County on March 15th with an excellent program and fair attendance. Several 50 year certificates and pins have been awarded to physicians in the district during the current year.

Your Councilor has attended all of the meetings of the Council except one, which occured during his absence from the country on other medical business. He has attended all the meetings of the various Committees of which he is a member, with especial attention and time given to the Finance Committee and the Public Relations Committee.

Your councilor wishes to thank the Officers of the Component County Societies for their cooperation the past year. He regrets the inability to attend more meetings of the component societies.

Your Councilor wishes to thank the Office of the Secretary for the cooperation and courtesies extended him in the past year.

E. S. Hamilton, M. D.
*Councilor, Eleventh District.*

## COUNCILOR-AT-LARGE

To the Members of the House of Delegates:

As Councilor-at-large I leave the official family of the Illinois State Medical Society inspired with the currently popular song entitled: "Moments to Remember."

Every moment served with the organizations as councilor, President-elect, President and Councilor-at-Large has been more thrilling than the last one. I shall always remember these happy days. The privilege of meeting not only the past and present members of the official family but also becoming acquainted with each County Medical Society Officer and the many members of the State Medical Society has been of inestimable value.

A few of the outstanding objectives have been accomplished, namely: The consolidation of the Chicago office, the publishing of the book entitled. "The History of Medical Practice in Illinois from 1850-1900." and the fact that Illinois is the pioneer and leading State in contributing to the American Education Foundation.

The Society has been transfused with new blood by the addition of new and young councilors, and by lay personnel of high caliber.

I shall be eternally grateful to all of you for the help, advice and moral support which was so unselfishly given me.

Respectfully submitted,

Arkell M. Vaughn, M. D., *Councilor-at-Large.*

# Reports of Standing Committees

## MEDICAL SERVICE AND PUBLIC RELATIONS

To the Members of the House of Delegates:

The Committee has held five meetings since its last

report, all of which have been well attended; and one of which was a joint meeting with representatives of the Illinois State Dental Society.

The Reference Committee considering the report of the Committee on Medical Service and Public Relations last May recommended:

1. That the basic committee be enlarged to include more "grass roots public relations people from component societies and that this might well be implemented under the By-laws of the Society by taking advantage of the following quotation from Chapter IX, Section 3, 'Each component society shall appoint one member to act as advisor to this committee'.."
2. That a more comprehensive statewide public relations program be developed to encourage every county society to formulate a local program suitable to the area needs, such as (a) emergency call systems, (b) speakers' bureau, (c) new physician contacts, (d) insurance activities, and (e) community services.
3. That closer liaison through the State Society and to the component societies be set up with the public relations department of the AMA so that all groups will have the benefit of these efforts and materials.
4. Promote the exchange of public relations materials and plans among the component societies of Illinois and act as a clearing house to accomplish this end.

These problems were presented to the Council of the Illinois State Medical Society by the Chairman of the Committee on Medical Service and Public Relations at the August 7 meeting for Council consideration and implementation.

The Committee was instructed to ask each county society to appoint a representative (as provided under the Bylaws) if such action had not already been taken as a result of similar requests in the past.

The Chairman of the Committee on Medical Service stated to the Council that the intensive work of Mr. James C. Leary to organize the county societies and to work with the various representatives in his trips throughout the State, had been quite popular for a short time. The material developed relative to a public relations program at the county level has been printed and distributed under the title: "The Public Relations of County Medical Societies: Outline of Program".

The Council suggested that one-half day be alloted to the public relations representatives of the various county societies when the "Secretaries' Conference" was held in Springfield during the winter. This, plus the annual public relations dinner held during the annual meeting, should help solve the "contact" problem. Councilor district meetings were suggested also.

The fact that the AMA mails public relations material direct to the county medical societies was stressed, and the fact brought out that the success of any public relations program depends upon the way it is handled at the local level.

Any inquiry or request for assistance (sent to the Committee on Medical Service and Public Relation, Suite 1909, 185 North Wabash Ave., Chicago 1) will receive the attention of the Committee immediately.

The Committee in accordance with the above recommendations caused letters to be written to the county medical society secretaries asking them to (1) appoint an Advisor to the Committee on Medical Service and Public Relations, (2) stimulate local programs suitable for area needs, as a part of a more comprehensive statewide medical public relations program, (3) supply the Committee with names and addresses of the Public Relations Chairmen, as well, as the Legislative Chairman. A Questionnaire was prepared covering the above points, to which there was good response. Two additional letters were sent to the secretaries who did not reply to the first one, and as a result, all but nine counties in the State were heard from. This information has been compiled and addressograph plates made so that it is possible to contact these men quickly.

Mr. John W. Neal continues to serve as legal consultant for the State Medical Society, and he is frequently called upon to render service in connection with the activities of the Committee. His valuable contacts, experience and knowledge of medical-legal and legislative problems render him almost invaluable to the Society. During a part of the time the Legislature was in session last year in Springfield, because of the illness of Mr. Oblinger, it was necessary for Mr. Neal to spend considerable time in Springfield, with great benefit to the Society.

Mr. Edward A. Uzemack has been engaged as Director of Public Relations and Assistant Secretary of the Illinois State Medical Society, and has been engaged in that capacity since April 1, 1956. His addition to the staff should go far toward implementing the work of the Committee on Medical Service and Public Relations.

For the past three years Mr. Uzemack has been Executive Assistant in the Department of Public Relations of the American Medical Association, prior to which he has held governmental positions, as well as those of a reporter and rewrite man for the Chicago Times and the Chicago Sun-Times.

Members of the society are urged to contact Mr. Uzemack in connection with any problems regarding public relations that may arise in their society, it being the feeling of the Committee that the office of Director of Public Relations should be one whose services are available to any component Medical Society.

This policy has worked very well for many years. It has been productive of much good feeling between the component County Medical Societies and the Illinois State Medical Society.

The situation which developed as a result of the dentists' desire to amend the Enabling Act in order to participate in the existing Blue Shield Plans, and which resulted in the adoption of a resolution by the House of Delegates in May, 1955 opposing H. B. 950, has resulted in further conferences with officers of the Illinois State Dental Society. The entire Public Relations Committee and officers of the Illinois State Society met recently with the officers and a Committee from the Illinois State Dental Society in an effort to arrive at an amicable agreement in regard to this matter. Further conferences are in the offing, and it is hoped that satisfactory solution to this problem will be reached. The medical and dental professions have so many interests in common in the health care of the people, that no difficulty should be encountered in reaching such a satisfactory solution.

Despite a frantic and hectic session during the 69th General Assembly, in retrospect, we are happy to report that the Illinois State Medical Society had a most successful legislative year. Specific bills affecting medicine were Senate Bills 709 and 710, the so-called osteopathic bills, which would permit osteopaths to prescribe drugs and medicines and to do surgery and to place two osteopaths on the medical Examining Board. Senate Bill 709 was defeated in the Senate by a vote of 31 to 5, while its companion bill, Senate Bill 710 was rejected by the House by a vote of 38 to 55. After this defeat, a further bill, Senate Bill 877, was introduced calling for the investigation of limited licenses under the Medical Practice Act. This bill was passed by the Senate without adequate consideration but was rejected by the House by a vote of 54 to 43.

This Society' introduced Senate Bills 247 and 248, the so-called coroner's bills, seeking to require medi-

cal opinions on the cause of death and to create an advisory board. Both of these bills were passed by an overwhelming vote—in the Senate by only one or two dissenting votes, and in the House by a margin of 94 to 7. Unfortunately the Governor saw fit to veto Senate Bill 247, saying in effect that it interfered with home rule and would place an unconscionable tax burden upon county boards of supervisors. He approved Senate Bill 248, but to date has not appointed the advisory board. This Society also endorsed Senate Bill 758, seeking an appropriation of $780,000 to the Department of Health for the maintenance and expansion of premature baby care in this state. This bill was passed by an overwhelming vote of both Houses and was signed into law by the governor. The Society secured favorable action on other bills in which it was interested.

In connection with the Society's legislative activities and in an effort to disseminate current information pertaining to the progress of legislation to all interested persons, a special legislative service in the nature of a Springfield Newsletter was initiated and a total of twenty-five issues were published. Beginning in November of 1955, a special series of this Newsletter was started to supplement A. M. A.'s legislative program. Special issues were devoted to H. R. 7225, the Bricker Amendment, the Jenkins-Keogh Bills, and Reinsurance. It is anticipated that other issues will be published from time to time as the need arises.

Your Associate Counsel has made numerous public appearances, speaking on items of interest to the medical profession, before hospital groups, component societies, the auxiliaries, scientific societies, postgraduate conferences, secretary's conference, and civic groups.

The Associate Counsel has been active in other ways in appearing before state agencies, attending A. M. A. meetings and conferences, attending the Council meetings of the Illinois State Medical Society, participating in committee activities, writing legal opinions on various medico-legal subjects, and investigating grievances.

Numerous other activities of the staff of the Committee have been carried on during the year, including participation in the observance of Farm Week, October 23-29, which was observed by the Kiwanis Clubs throughout the United States; the resumption of the monthly PR Page in the Illinois Medical Journal, and an additional experimental weekly Medical Digest which was sent to the Officers and Councilors of the State Society. These, however, were carried on principally by Mr. John Mirt, who has been working in the office of the Illinois State Society since last April. A considerable amount of work has been done for the Woman's Auxilary, including the planning of a program director, publicity for the Annual Fall Conference, and press and publicity in connection with their Annual Meeting. This work was done by Mrs. Rutherford.

Widespread publicity was given to the selection of Dr. Elbridge W. Telford of DeKalb as the Illinois General Practitioner of the Year. An album was prepared by Mr. John Mirt, and presented to the American Medical Association in connection with the state society's nomination of Dr. Telford for national honors. A further release was prepared and sent out when Dr. Telford received the Korean government's Distinguished Military Service Medal.

In line with our policy to assist county medical societies in their public relations program, the services of the Committee were extended to the Chicago Medcal Society for their recent Annual Clinical Conference. Mr. Mirt and Mrs. Rutherford actually handeled the entire publicity for that meeting. In addition to preparing all of the advance material, they spent four days in the pressroom at the Palmer House. As a result of their efforts, the Chicago Medical Society received widespread publicity, which brought a letter of appreciation from Dr. H. Kenneth Scatliff, chairman of the Chicago Medical Society Executive Committee.

This Committee also prepared speech material for Councilors and others called upon to make addresses before professional or other groups.

Assistance was also rendered to the Illinois Medical Journal in the preparation of articles for publication and in the reading of proofs.

The services of Mrs. Rutherford were also extended to the Committee on Industrial Health, the Editorial Board and Journal Committee, and to officers in need of stenographic service when they came into the Chicago office.

Respectfully submitted,

PERCY E. HOPKINS, *Chairman*
EDWIN S. HAMILTON, M. D.
EVERETT P. COLEMAN, M. D.
LEO P. A. SWEENEY, M. D.
E. A. PISZCZEK, M. D.
*Committee on Medical Service and Public Relations.*
F. GARM NORBURY, M. D.
JOSEPH T. O'NEILL, M. D.
HAROLD M. CAMP, M. D.
*Ex-Officio*

DR. HOPKINS: I have a supplementary report. This report has been agreed to by four of the five members of the Committee, Drs. Hamilton, Sweeney, Piszczek, and myself. We have not been able to get in contact with Dr. Coleman this morning or last night. For that reason, Dr. Coleman while he has had this supplementary report submitted to him, has not signified his attitude in regard to it. This is the supplementary report.

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The following Supplementary Report of the Committee on Medical Service and Public Relations is submitted for your information and consideration:

It will be noted that in the final program of the activities during this annual meeting of the Illinois State Medical Society as published in the Handbook for Delegates, and elsewhere, the annual dinner meeting and program sponsored by the Committee on Medical Service and Public Relations has been omitted. This dinner meeting and program has been abandoned.

It is the feeling of the Committee that an explanation of this situation to the House of Delegates is in order.

It will be recalled that in recent years more and more people have been attracted to this function, and have come to look forward to it as an integral part of the annual meeting. Perhaps some of the reasons for this have been an improvement in the type of program offered; and an increased interest in public relations on behalf of county medical societies; absence of other organization meetings or dinners at the same time, and also the encouragement of attendance at this meeting by the Council of the Illinois State Medical Society by subsidizing, wholly or in part, the cost of the dinner, in addition to the expenses incurred in obtaining speakers. The Committee wishes to emphasize the wholehearted cooperation and helpful policy of the Council in this regard.

At the Council meeting on January 29, 1956, the Committee recommended that the annual dinner meeting and program be held on Tuesday, May 15, 1956, and that the Public Relations Chairmen of the county medical societies be specifically invited. The Committee further recommended that the cost of the dinner tickets be established at $3.00 per person, with the State Society assuming the additional cost of the dinner. These recommendations were unanimously adopted by the Council.

At the Council meeting on April 22, 1956, attention of the Council was directed to the fact that the program of the Woman's Auxiliary contemplated a buffet

supper and entertainment to be held the same evening. It was the understanding of the Committee that the Woman's Auxiliary had been invited by the Council to take over the program of Hospitality Night, which has always begun at 9:00 p. m., and has never heretofore been held earlier. Furthermore, it was the distinct understanding of the Committee that the program of the Woman's Auxiliary for that evening would not begin until the Public Relations dinner and program had been completed.

Although assurances of wholehearted cooperation and offers to participate in the promotion of the Public Relations dinner meeting were received from the officers of the Woman's Auxiliary, publicity of the Auxiliary's "First Annual Doctors' Dav" program appeared in the Bulletin of the Chicago Medical Society of April 21, 1956, announcing the social hour beginning at 7 o'clock and buffet supper at 8:30 o'clock. Previous letters sent to the branch officers, as well as tickets to the entertainment, announced the beginning of the social hour as 7:00 p. m. The Illinois Medical Journal for April 1956 in the program summary on page 188 announced the Public Relations dinner at 6:00 p. m., and a program and buffet supper in cooperation with the Woman's Auxiliary at 9:00 p. m.

Speakers had been engaged for the Public Relations program, some from out of town; a letter of invitation announcing the program had been mimeographed and was about to be sent to the officers and Public Relations chairmen of county medical societies at the time of the last Council meeting on April 22.

Considerable discussion in regard to this matter ensued at this Council meeting in the interest of the welfare of the Illinois State Medical Society, and the Committee on Medical Service and Public Relations was authorized to hold the dinner some other evening during the annual meeting, or at a subsequent date in the fall.

The Committee on Medical Service and Public Relations is entirely mindful of the many valuable contributions of the Woman's Auxiliary and publicly acknowledges their responses on the many occasions that the Committee has called upon it for help, as well as their continuing efforts as an auxiliary to the Illinois State Medical Society. However in connection with the meetings above referred to, the Committee on Medical Service and Public Relations regrets the misunderstanding which resulted in a lack of cooperation and responsibility in carrying out the first principle of the Constitution of the Woman's Auxiliary to the Illinois State Medical Society, which is: "To assist the Illinois State Medical Society in its program for the advancement of medicine and public health."

It would seem to the Committee on Medical Service and Public Relations that this matter should be brought to the attention of the House of Delegates in order to preclude future complications resulting in the cancellation or abandonment of projects that heretofore at least have been deemed a vital part of the annual meeting of the Illinois State Medical Society.

Respectfully submitted,

PERCY E. HOPKINS, M.D.,
*Chairman*
*Committee on Medical Service and Public Relations.*

THE PRESIDENT: Dr. Hopkins' report will be referred to Committee "B", Reference Committee on Standing Committees, Dr. Whiting, Chairman.

## ARCHIVES

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

This Committee has not met officially during the past year, but its members have discussed activities for which it is responsible on two different occasions. Letters have been sent to all component County Societies requesting preservation of historical material. Some very interesting items have been forwarded to us during the year.

The John Crerar Library, 86 East Randolph St., Chicago 1, Illinois, has been selected as a depository for our State Archives. Please send articles of historical interest to Miss Ella Salmonsen, at that address.

Respectfully submitted,

TOM KIRKWOOD, M. D.
*Chairman.*
J. J. MOORE, M. D.
*Secretary.*
E. H. WELD, M. D.
*Committee on Archives.*

## MEDICO-LEGAL

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

No problems involving Medico-Legal liability has been referred to the Medico-Legal Committee during the year of 1955-1956.

There were three inquiries requesting legal opinions. These inquiries were referred to the legal counselor of the Illinois State Medical Society, Mr. John Neal. The counselor concurred in the opinion that these were purely legal matters not coming under the jurisdiction of the Medico-Legal Committee.

No meeting of the Medico-Legal Committee has been held during the year of 1955-1956, because no problems were referred to the committee for attention. If any important problems are brought to the attention of the Medico-Legal Committee prior to the meeting of the House of Delegates in May, 1956, an appropriate meeting will be called and the committee will submit its recommendations in a supplementary report to the House of Delegates.

The American Medical Association made a survey of liability insurance in 1955. The questionnaire was forwarded by the American Medical Association to the Medico-Legal Committee and it was completed with the aid of the legal counselor of the Illinois State Medical Society.

In the opinion of the most active carrier of professional liability insurance in the State of Illinois, there were three primary causes of malpractice litigation, which are:

1. Indiscrete and/or unwarranted comments or criticisms by other physicians.
2. Counter-claims alleging malpractice following lawsuits for fees filed on behalf of physicians.
3. Lack of proper doctor-patient relationship.

Respectfully submitted,

A. L. NICKERSON, M. D.
F. E. BIHSS, M. D.,
EDWARD C. HELFERS, M. D.,
RALPH MCREYNOLDS, M. D.,
LEO P. A. SWEENEY, M. D.,
GEORGE C. TURNER, M. D.
*Chairman,*
*Medico-Legal Committee.*

## MEDICAL BENEVOLENCE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

In the event there are some members who do not, perhaps, have a clear understanding of the purposes of the Benevolence Fund, your Committee gives its report in question and answer form.

WHAT IS THE BENEVOLENCE FUND?

It is a "trust fund" established sixteen years ago to be used in extending financial assistance to worthy, needy doctors and/or their widows and dependent children.

WHAT IS THE SOURCE OF THE FUND?

Each member of the State Medical Society automatically contributes two dollars from his dues annually; personal contributions; memorials; interest on bonds; and last, but certainly not least, are the generous donations from our Woman's Auxiliary.

WHO ADMINISTERS THE FUND?

The Benevolence Committee, including Dr. Har-

old M. Camp, Secretary, meets regularly to survey and classify new applications and review the status of current recipients to determine the continuance or adequacy of some grants, or the discontinuance of financial aid to others where a change in circumstances has altered the need for assistance.

WHERE ARE THE FUNDS KEPT?

These funds, consisting of Government Bonds, interest and other cash, are kept in a seperate account in a bank other than the one used for the general Society funds. The account and Bonds are held in the name of the Illinois State Medical Society Benevolence Fund.

HOW MUCH DOES IT COST TO ADMINISTER THE FUND?

Nothing. Not one cent from the Fund is used for postage, investigations or for any purpose whatever other than to make monthly payments to beneficiaries. The checks are sent regularly to the recipients from the office of the Secretary, Dr. Harold M. Camp, Monmouth, Illinois.

HOW MANY ARE RECEIVING MONTHLY PAYMENTS AT THE PRESENT TIME?

There are thirty-three (33) recipients, eleven (11) doctors and twenty-two (22) widows. Two (2) applications are presently being processed.

HOW DOES THE COMMITTEE BECOME AWARE OF A PROSPECTIVE APPLICANT?

Attention is directed to the Committee (1) by Dr. Camp, who generally receives the first inquiry or application. He, in turn, sends them on to the Chairman of the Committee. After the proper investigation, the Committee considers each case. If any require immediate action, they are processed through correspondence, etc., with Committee members after the customary investigation. (2) Inquiries come to the Committee from persons seeking assistance. (3) Requests come from the Medical Society in which the doctor has, or did have, membership, and (4) Neighbors and friends of prospective applicant.

HOW DOES ONE MAKE APPLICATION FOR ASSISTANCE?

After information is received indicating a possible need for assistance, a questionnaire is forwarded to applicant. This completed form is then studied. Further information is sought from a member, preferably, the Secretary, from the applicant's Medical Society to ascertain the financial status of the applicant. Finally, an investigation by a retail credit company is made which usually strengthens and verifies the request. This procedure is necessary due to a misunderstanding, sometimes, that the Fund is available on application.

ARE THE NAMES OF THE APPLICANTS EVER PUBLICIZED?

All names are held in strictest confidence. Only the total number of recipients is made known.

IS IT NECESSARY TO CONTINUE CONTRIBUTIONS TO THE FUND?

It is definitely necessary to keep the Fund at present level in order to meet ordinary and unforeseen emergencies. Unfortunately our recipients are being found, more and more, in the younger age brackets. Widows, with small children, are facing many perplexing problems because of the loss of young husbands whose brief establishment in medical practice failed to produce financial security for their families. Assistance for these young mothers will be needed temporarily, to tide them over the important period when necessity calls for their presence in their own homes.

WHAT RECOMMENDATIONS DOES THE COMMITTEE MAKE THIS YEAR?

The Committee recommends (1) that new application blanks be devised which will reveal additional information to expedite the processing of applications. (2) That a re-check by a retail credit company be made annually on all recipients with the exception of a few who are seen during the year and show that circumstances have not changed their status. (3) That a study be made of the advisability to establish a Home for elderly or incapacitated physicians and/or widows. (4) That physicians, in order to establish eligibility for aid for themselves (or widows) must have been a member of the Illinois State Medical Society for at least a *reasonable* number of years during the term of active practice of medicine.

COMMENTS:

This has been a most satisfying and gratifying year for your Committee on Benevolence. We are satisfied that the importance of the program is becoming better realized and that our recipients are all worthy of the assistance we can offer them. We are grateful to all contributors (with special sincere thanks to our fine Auxiliary members who have contributed $3,968.35 this past year); to Dr. Harold M. Camp and Mrs. Wanda Ross, his secretary, for the many hours of time they have devoted to the administration of this Fund; to the individuals who have assisted us in presenting information to determine the need for a claim; and our thanks, too, to the Council, whose understanding of our problems and encouragement made our task easier and more enjoyable. We were happy to serve in a capacity which enabled us to bring some degree of comfort and cheer to those less fortunate than we. It was done in your name!

Respectfully submitted,

NORMAN L. SHEEHE, M. D.
*Chairman,*
LEE O. FRECH, M. D.
F. M. NICHOLSON, M. D.
HAROLD M CAMP, M. D.,
*Secretary,*
*Committee on Medical Benevolence.*

## MEDICAL EDUCATION AND HOSPITALS

At a time when medical education and medical practice has reached its greatest degree of perfection, public sentiment toward physicians seems to be motivated by criticism. Why should the profession experience such a paradox, criticism at a time when praise seems just? The focal point of criticism is undoubtedly economic. To be ill today is a terrifying and crippling economic experience. But it appears to this committee that the public is poorly informed as to why the cost of medical care is high and how the patient's dollar is distributed. Hospital charges, laboratory charges, drug charges, anesthesia charges and nursing charges in almost every instance far exceeds the physician's fees. Why the accumulated economic discomfort derived from all phases of medical practice should be laid at the feet of the doctor is difficult to comprehend. Yet, it is more natural for man to spend his wrath upon the doctor, a person, than the hospital, the drug house, or the laboratory, impersonal institutions. It is the feeling of this committee that the medical profession as a whole expends little effort to point out to the patients the broad base of medical expense.

### HOSPITALS

This committee has viewed with some concern the current tendency of hospital authorities to solicit contributions from their staffs either to enhance future building funds or to aid in meeting current expenses. The practice carries with it all the dire consequences that could arise from buying one's position on a staff. It is too much to expect that large contributions from certain staff members will go completely unnoticed and unrewarded by the management. If the practice is to be continued it should be mandatory that all contributions be anonomously given. Since solicitation of funds is likely to continue, the Medical Society should study its effects on medical fees and staff morale.

### MEDICAL SCHOOLS

At the moment there are 81 medical schools in the United States. In 1955 these schools administered

to 28,583 medical students—which represents an increase of 16,053 medical students or 128% over the enrollment in 1910. During this same period the population of the United States increased by 80% showing that medical graduates have exceeded the general population growth by 48%. The fact that there is one doctor to every 730 persons in the United States further emphasizes the adequacy of medical personnel.

The ratio of medical school admissions to the number of applicants in 1954-55 is 1 to 1.91 or 7,576 admissions from 14,538 applicants. In the freshman class of 1954-55, 17% of the students had an A average in premedical college work, 69% had B averages and 14% could claim only a C average. It is quite obvious then that the medical schools are willing to take many B students and a few C students.

The cost of educating medical students is high and most schools need financial support. Funds available for operating medical schools during the year 1955-56 approximate $160,000,000. Of this $98,012,621 represents budgeted funds and appropriations, the rest comes from research and teaching grants. It is important to note that tuition will produce $19,210,304 or approximately 19% of the budgeted funds. To present this discrepancy more dramatically it may be pointed out that it costs $10,000 to $12,000 to train each medical student during his four years—of this amount the student's tuition represents $2,906, leaving a deficit for each student of from $7,000 to $9,000.

Of the 81 medical schools in the United States 41 are privately owned, 37 are operated by the state and 3 by municipal authorities. The sources of the basic medical school operating budgets during 1955-6 are as follows:

| *No. of Schools..Source of Funds* | | *Pctg. of Total* |
|---|---|---|
| 48 | Govt.-State-City | 48.7% |
| 47 | Endowment Income | 10.6% |
| 81 | Tuition | 19.2% |
| 34 | General University Funds | 6.3% |
| 78 | Gifts, Grants and Other | 15.2% |

It is interesting to note that there are seven new medical school being developed in the United States. Of these the University of Miami will graduate its first class this year—and bring the total number of medical schools to 82. The other medical schools, all of which will reach maturity by 1960 include:

1. University of Mississippi
2. University of Missouri
3. West Virginia University
3. Albert Einstein
5. Seton Hall
6. University of Florida

INTERNES

The matching program for internes has now been in operation for 4 years. During its fourth year, starting July 1, 1955, 814 participating hospitals attempted to fill 11,075 internships from the 6,713 students that participated in the plan. As evidence of the effectiveness of the plan it is worth while to note that 76% of the students obtained their first choice, 14% their second choice, 5 per cent their third choice and 5 per cent their fourth or higher choice. That both the hospitals and students have accepted the plan is evidenced by the fact that in 1955 the hospital membership was 98½ per cent and the student participation represented 97 to 99 per cent of eligible seniors.

The smaller hospitals requiring 1-9 internes make up 80 per cent of all the hospitals receiving no matched students. Teaching opportunities seems to affect student choice of hospitals for internship. Thus, hospitals unaffiliated with a teaching institution filled 40% of their available internships. Those with minor teaching connections filled 66% and those with major teaching opportunities filled 79% of their internships. The monetary attraction does not appear to be as potent as one might expect. Thus, in 1950, 80% of the total number of matched internships went to hospitals with a monthly stipend of $100.00 or less.

Respectfully submitted,
GEORGE F. O'BRIEN, M. D.,
*Chairman.*
KARL LEROY VEHE, M. D.
HARLAN ENGLISH, M. D.
*Committee on Medical Education and Hospitals.*

## MEDICAL TESTIMONY

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The report of the Medical Testimony Committee is quite brief. No cases were presented to it for investigation and no decisions consequently were reached. However, a meeting was held at which four men from Central Illinois attended. It appears that there are sub-committees in Central Illinois which take care of most of the medical legal problems satisfactorily.

In the future, the committee ought to contact and cooperate with the Illinois State Bar Association in order to develop plans for more uniform satisfaction in matters pertaining to medical testimony. Medical testimony has to do, both, with the medical profession and the legal profession, a fact which has been recognized in some other states.

It will take some time before those with justifiable complaints learn that this committee can be relied on to keep the complainant's name confidential. This appears to be one of the draw-backs in obtaining complaints.

Respectfully submitted,
ADRIEN VERBRUGGHEN, M. D.,
*Chairman*
EVERETT P. COLEMAN, M. D.
JOHN H. GILMORE, M. D.
MAURICE D. MURFIN, M. D.
WALTER L. PALMER, M. D.
A. F. GOODYEAR, M. D.
HARRY A. OBERHELMAN, M. D.
E. H. WELD, M. D.
*Committee on Medical Testimony.*

## GRIEVANCE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Grievance Committee is happy to report that they have received directly only 5 complaints in the past year. This is in conformity with previous years when in 1951 there were 6 complaints, 1952—6, 1954—3, and 1955—4.

Alleged excessive fees was the grievance in only 2 cases. Grievances were received from 2 attorneys, one for alleged excessive fees following an auto accident and the other against a physician who was tardy in filling out an insurance accident report. The complaints were referred to the councilors of the various districts from which the grievance arose who in turn referred them to the secretary of the respective county medical society who likewise referred them to the local grievance committee if one was available for local action

The councilors in whose district the grievances arose are to be congratulated for their interest and unbiased and fair disposition of the cases. Two cases have been settled, 3 are pending action by the local grievance committee.

One meeting was held during a regular council meeting and all the members of the committee were present except one. A booklet entitled "Guides for Medical Grievance Committees" as published by the American Medical Association is in the hands of all the committee members and it is urged that all members of the state society secure one of these guides.

In only 5 instances this year was it necessary to refer complaints to the State Grievance Committee. On all other occasions grievances have been considered

by committees at the county level. This speaks well for the organization of committees throughout the component societies. This is especially gratifying since a fair segment of our society is composed of younger physicians and since some lay publications would have the public believe that physicians, and especially the younger physicians, are interested only in money and Cadillacs. The above verified the caliber and sincerity of all our members and especially the younger physicians who will steer, we are sure, the destiny of the Illinois State Medical Society into safe channels in the future.

The Committee respectfully suggests that changes in amendments to the By Laws be considered that will provide for an appeal from the decision of component society grievance committees. Such a provision is totally lacking at present and the committee is of the opinion that either party to a complaint should have the right to appeal the decision of a component society to the state society committee.

Respectfully submitted,

ARKELL M. VAUGHN,
*Chairman.*

PERCY HOPKINS
EDWARD WELD
WILLIS LEWIS
HARRY MANTZ
EDWIN BAKER
*Grievance Committee*

## Report of Editorial Board and Journal Committee

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

During the past year three full committee and two sub-committee meetings of the combined Journal Committee and Editorial Board have been held. The full committee meetings were devoted to the overall composition and policy of the Journal while the sub-committee meetings considered primarily editorial procedures.

At the various meetings the committee has re-evaluated the contents and make-up of the Journal and much consideration has been given to the scientific material in an effort to provide articles of interest and value to both the specialist and the general practitioner. In this endeavor many articles have been carefully screened and discussed by the Editorial Board prior to publication. In other sections of the magazine, articles on Medical Economics, Public Relations, Medico-Legal subjects, Pathologic Conferences, and the like, have been continued as in past years. A new department giving activities of various hospitals and medical schools has been added. Another addition has been the use of medical cartoons and under current consideration is a column similar to "Tonics and Sedatives" in the JAMA.

Additional matters considered and acted upon during the year have been:

1. A new method to provide more efficient and effective review by the Editorial Board of papers submitted for publication has been recommended.
2. A requirement that all papers be submitted in two copies so as to expedite the editorial processing has been established.
3. An improved method of proof-reading has been developed in an effort to eliminate typographical errors.
4. Council approval has been secured to publish the Proceedings of the House of Delegates at the Annual Meeting as a supplement to the Journal.
5. A policy on furnishing reprints, consistent with that of the JAMA, has been established and received Council approval.
6. Advertising rates have been increased 10 per cent to 20 per cent to balance increased costs of publication. This has been accomplished without the loss of any advertisers. Some new advertisements have been secured.
7. Specification sheets have been prepared to secure bids from various printing firms for the ensuing year.

The committees would like to commend the Editors, Drs. Harold M. Camp and Theodore Van Dellen, and the Journal Business Manager, Mr. Ed Malley, for the tireless efforts they have expended to make the Illinois Medical Journal an outstanding publication and for their cooperation with the Journal Committee and Editorial Board. The sincere assistance of Mrs. Clara Mai Rutherford and Mr. John Mirt is also gratefully acknowledged.

Respectfully submitted,

JAMES H. HUTTON, M, D.
*Chairman, Editorial Board.*
JOSIAH J. MOORE, M. D.
JOHN R. WOLFF, M. D.
FREDERICK H. FALLS, M. D.
EDWARD F. WEBB, M. D.
ARKELL M. VAUGHN, M. D.
EDWIN F. HIRSCH, M. D.
SAMUEL A. LEVINSON, M. D.
JOHN T. REYNOLDS, M. D.
RALPH C. AIKEN, M. D.
F. L. LEDERER, M. D.
MARY KARP, M. D.
F. J. GERTY, M. D.
JACOB E. REISCH, M. D.
*Editorial Board*

JACOB E. REISCH, M. D.,
*Chairman, Journal Committee.*
JOSEPH T. O'NEILL, M. D.
ALBERT VANDERKLOOT, M. D.
JOHN LESTER REICHERT, M. D.
PAUL P. YOUNGBERG, M. D.
RALEIGH C. OLDFIELD, M. D.
*Journal Committee*

## Report of Delegates to AMA

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Your delegates to the American Medical Association attended the House of Delegates meetings in Atlantic City in June, 1955, and Boston in November and December, 1955. The following summary of some of the more important transactions is respectfully submitted for the information of the House of Delegates of the Illinois State Medical Society.

The Distinguished Service Award, a gold medal, was voted to Dr. Donald C. Balfour of Rochester, Minnesota.

The report adopted by the House of Delegates, which was a minority report of the Committee for the Study of Relations between Osteopathy and Medicine, recommended that the report be received and filed, and that the Committee be thanked for its diligent work, and be discontinued. Also, that if and when the House of Delegates of the American Osteopathic Association, their official policy making body, may voluntarily abandon the commonly so-called osteopathic concept, with proper delineation of said osteopathic concept, from catalogs of their colleges, and may approach the Trustees of the American Medical Association with a request for fur-their discussion of the relations between osteopathy and medicine, then the said Trustees shall appoint another special committee for such discussions.

The Reference Committee on Miscellaneous Business dealt with ten resolutions concerning the dispensing of drugs and appliances by physicians. The following report was adopted by the House. Section 8, Chapter 1 of the Principles of Medical Ethics was deleted and a new Section 8 was substituted and adopted. This Section 8 now reads: "It is not unethical for a physician to prescribe or supply drugs, remedies or appliances, as long as there is no exploitation of the patient." In re-

commending the change in Section 8, the Committee emphasized that this Section should be interpreted in line with Section 6, Chapter 1, which reads: "The ethical physician engaged in the practice of medicine limits the sources of his income received from professional activities to service rendered to the patient."

The Reference Committee on Internship Approval reaffirmed the following recommendations of the Ad Hoc Committee on Internship:

1) That a continuing study be made as to what should be the content of an internship; what constitutes sound clinical experience during the internship.

2) That the one-quarter rule be adopted. Any internship program that in two successive years does not obtain one-quarter of its state complement, be disapproved for intern training. It was pointed out to the Committee from data compiled for a period of two years that enforcement of the rule would have displaced only a few interns.

Six resolutions having to do with Hospital Accreditation provided a recommendation by the Reference Committee, which was adopted, that the Speaker of the House of Delegates be requested to appoint a Special Committee to review the functions of the Joint Commission on the Accreditation of Hospitals, this Committee to consist of seven members, none of whom shall be members of the Council on Medical Education and Hospitals. This Special Committee should be instructed to make an independent study or survey and report its findings and recommendations to the House of Delegates at the next annual meeting. All physicians and hospitals are urged to pass on to this Special Committee any observations or suggestions concerning the Joint Commission on the Accreditation of Hospitals.

Three resolutions having to do with poliomyelitis vaccine were adopted by the House in which 1) Confidence in the established methods of announcing new and possibly beneficial methods in the treatment and prevention of disease, and the presentation of reports on medical research before established scientific groups, allowing free discussion and criticism of the methods employed and data acquired in recognized scientific publications; 2) Congress was urged to allow the Salk Poliomyelitis Vaccine to be produced, distributed and administered in accordance with past procedures on any new drug or vaccine. The third resolution expressed the profound gratitude of the House of Delegates to Dr. Salk. and its admiration for his monumental contribution to medical science.

The House of Delegates reaffirmed its previous recommendation that the United States withdraw from the International Labor Organization.

The Headquarters Survey Report was approved, which included the statement that "the only public relations program of any permanent value is the private and public relations of the individual doctor."

The House reaffirmed its opposition to extension of the Doctor-Draft Law.

It recommended the creation of an American Medical Association Committee on Geriatrics.

The House also adopted a resolution warning against the danger embodied in state legislative proposals designed to restrict the entire field of visual care to the profession of optometry.

Dr. Dwight H. Murray of Napa, California, was elected President-Elect, Dr. George Lull of Chicago, Secretary, Dr. J. J. Moore of Chicago, Treasurer, and Dr. Harlan English of Danville was elected to the Council on Medical Education and Hospitals. and Dr. Warren W. Furey of Chicago to the Council on Constitution and Bylaws.

At the Clinical Session in Boston, Dr. E. Roger Samuel of Mt. Carmel, Pennsylvania, was awarded the medal and citation presented annually for community service by a family doctor.

Social Security was the subject of much discussion at the meeting. Several resolutions were introduced concerning this subject. The Reference Committee on Legislation and Public Relations combined several resolutions and supplementary reports of the Board of Trustees, and substituted therefor a resolution providing the following policy: "That the American Medical Association reiterate in the strongest possible terms its determination to resist any encroachment on the American system of medical practice which would be detrimental to the American people; that the American Medical Association urge and support the creation of a well qualified commission, either governmental or private, or both, to make a thorough and impartial study of the economic, social and political impact of Social Security, both medical and otherwise, and that the facts developed be the sole basis for objective, non-political improvements to the Social Security Act.

The House adopted a resolution providing for the state societies to poll their entire membership on the question of inclusion in the Social Security Act, the results of such poll to be transmitted to the Board of Trustees of the American Medical Association as soon as possible.

The House adopted a substitute resolution brought in by the Reference Committee on Insurance and Medical Service to implement the findings and recommendations of the Committee on Medical Practice which studied the basic causes leading to certain unethical practices and unfavorable publicity. This resolution, which is subject to review by legal counsel, included among others, the following recommendations: 1) that a continuing committee on Medical Practice be created in the American Medical Association to conduct a study of the relative value of diagnostic, medical and surgical services, and to report its findings and recommendations in the same manner now followed by other committees and councils; 2) the Committee to consist of five members of the House appointed by the Speaker, three of whom shall be General Practitioners. The Committee is directed to utilize all possible means to stimulate the formation of a Department of General Practice in each medical school; 3) the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that Body leading to the warning, provisional accreditation or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence, after appeal to the Commission by the county medical society concerned; 4) that the Committee cooperate in every way in presenting a program of public education designed to bring about a better understanding of all fields of medical practice; 5) that the Committee use its full influence to discourage any arbitrary restrictions by hospitals against General Practitioners as a group or as individuals.

In a complementary action another report by the same Committee was adopted, which suggests that all non-surgical groups be asked for their suggestions and cooperation in carrying out a public education program on the value of diagnostic and medical care, and the various specialty boards are to be encouraged to reappraise the practice restrictions on their board diplomates.

Continued in this report is a statement that: "Organized medicine is ready, willing and able to solve satisfactorily its own problems, and such assurance should be given to the American Hospital Association, or any other group concerning itself with such problems."

The House approved the report of the Committee to recommend guides for Grievance Committees, and commended the Committee for their superb approach to the problem. The purpose of the guide is to promote a better understanding of the purposes of Griev-

ance Committees without interfering with the inherent autonomy of the constituent medical associations.

The House adopted a resolution to the effect that all resolutions dealing with changes in the Principles of Medical Ethics shall be considered over a period between sessions of the House before final adoption.

Other actions by the House recommended that the Board of Trustees give consideration to a dues increase for the purpose of contributing such increase to the American Medical Education Foundation.

It recommended that further purchase and distribution of Salk vaccine be carried on by the presently available commercial avenues used for other immunizing agents.

It also approved appointment of an American Medical Association Committee to Study the Prevention of Highway Accidents.

It also received progress reports from the Commission on Medical Care Plans, and from the American Medical Association Law Department on its statements of professional liability.

A resolution was adopted congratulating the physicians of Iowa for their efforts in supporting the position that the practice of medicine is the right of the individual. . .

The American Medical Association Board of Trustees announced that it had again appropriated $100,000 to be contributed to the American Medical Education Foundation for the support of medical schools. The contribution of the Illinois State Medical Society to this fund has amounted to more than $186,000 for the past two years, and while acknowledgment was properly made before the House of Delegates of this donation, it was the feeling of the delegates of the Illinois State Medical Society that more publicity might well be given to Illinois' effort in this project. This matter has been discussed with the officers of the Illinois State Medical Society, and efforts are now being consumated to remedy the situation as it previously existed.

Respectfully submitted,

PERCY E. HOPKINS, M. D.
*Chairman.*
WALTER C. BORNEMEIER, M. D.
EVERETT P. COLEMAN, M. D.
WARREN W. FUREY, M. D.
BURTIS E. MONTGOMERY, M. D.
J. M. PFEIFFENBERGER, M. D.
CHARLES H. PHIFER, M. D.
H. KENNETH SCATLIFF, M. D.
C. P. WHITE, M. D.
HARLAN ENGLISH, M. D.
*Delegates to American Medical Association.*

## REPORTS OF COUNCIL COMMITTEES

### ADVISORY COMMITTEE TO I. P. A. C.

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Your Medical Advisory Committee has been very active and busy during the past year in attempting to resolve some of the many problems which arise in the Medical Care Program to the recipients of aid from the Illinois Public Aid Commission.

The committee has held eight regular meetings in Chicago to which many chairmen and members of Local County Medical Advisory Committees have been invited and have attended. There have been two meetings of the subcommittee on Radiology and one of the subcommittee on Ophthalmology.

Also, individual members of the Profession who have had particular problems, have been invited to attend the State Committee meetings, where an attempt has been made to solve the difficulties.

Your committee would like to mention and elaborate in three particular problems.

1. Increasing and prolonged Hospitalization.
2. Excessive prescribing and dispensing of drugs, particularly the new and expensive drugs.
3. Excessive and unnecessary medical care including the routine use of many diagnostic procedures which are not consistent with the diagnosis given.

We all know, with reference to problem No. 1, that it is the tendency for any group receiving care for which they have no financial responsibility to be more demanding than the individual who assumes the financial responsibility of his own care.

We also know that there has been a break down of the moral responsibility of the family, particularly with reference to elderly people, thus shifting the burden of care to the Doctor and the Hospital.

In problem No. 2 there have been numerous instances in which tremendous drug bills have been presented. In many of these cases a private patient would revolt if asked to pay similar bills for their drugs, in fact the financial burden would be beyond reason.

Certainly, in the care of all sick people, discretion should be used in all medical procedures. The overall cost of medical care in the nation has risen 9% since 1952. A great part of this responsibility rests with the medical profession itself.

We all know that use of penicillin in the treatment of the common cold is not medically justified. This same situation can be applied to numerous expensive medications. Our problem is to give these recipients essential medical care within limits of the financial budget established by the Legislature.

In problem No. 3 with reference to excessive medical care and the excessive use of diagnostic procedures your committee feels that the great burden of responsibility lies with each individual Doctor. Certainly not all or even half of the patients coming into the Doctor's office needs a complete diagnostic work up.

Your committee is continually struggling to protect the rights and freedom of the Profession and the Practice of Medicine in Illinois.

Two Major accomplishments are to be noted this year. First, the markup on dispensed drugs was increased from 5% to 20 . Second, the number of visits to the Doctor's office which could be paid for one month was increased from three to six in an acute illness.

The fee schedule, as determined by consultation with all county Medical Societies in the State, is the most liberal in all the Nation.

Your committee has its continuing responsibilities for advising the Illinois Public Aid Commission with regard to professional matters, both on a general and individual case basis, and has continued to establish closer relationship with County Medical Advisory Committees, by having chairmen of these Committees attend the meetings of the State Committee.

It also became the duty of this Committee to work out a plan for the inoculation of these eligible recipient children with polio vaccine. Every County Medical Society in the State had a letter from the State Secretary's office advising them of our recommendations. To date only a very few societies have reported any action regarding this problem.

"Following are some of the facts about the Public Assistance loads:

After declining for eight consecutive months, the recipient loads rose by 6,100 persons in December 1955. The year-end rise was entirely in General Assistance, as increases in aid to Dependent Children and Disability Assistance were offset by decreases in Old Age Assistance and Blind Assistance. Seasonal factors accounted for the major portion of the December increase in General Assistance, but the size of the increase indicated the residual effects of the recent slowdown were also a factor. The increase in December 1955 was considerably smaller than occurred in either December 1953 or 1954. However, it was somewhat high-

er than in the preceding two years before the onset of the economic readjustment late in 1953.
Expenditures in December 1955 amounted to $12,572,073 an increase of almost $67,000 over November. The average cost per recipient was $45.57. In the Old Age Assistance program 5,000 fewer persons were receiving assistance at the end of 1955 than a year earlier. Unlike the Old Age Assistance program, the trends in Aid to Dependent Children continued upward in 1955. The uptrend in this program began in January 1954 and rose in every month of 1954 and 1955, except for November 1954 when there was a small decline. Increases were due to some extent to the rate of speed at which cases have been transferred from General Assistance, but increases for the winter months were due to the usual seasonal rise. Against the national trend, the Blind Assistance load in Illinois dropped again in 1955, this time by 112 persons. The trend in this program has been consistently downward for many years. Since 1945 the drop has amounted to 1600 persons, or 31 per cent. Rehabilitation, blindness prevention programs, medical advances, and other factors are credited with the decline.
The disability Assistance load continued to rise in 1955 but at a slower rate than in any year since the inception of this program in December 1950. The Public Assistance Code was amended in July 1955 to relax that portion of the definition of permanent and total disability relating to the totality of the disability. The revisions in the Code are reflected in Rules and Regulations on Determination of Permanent and Total Disability adopted by the Commission. The immediate effect of the revisions is to make possible acceptance of applications from individuals with a permanent disability who, under the previous Code provisions, were not eligible because their permanent disability was not considered a total handicap in relation to gainful employment. It is anticipated that a large but unknown number of severely handicapped individuals now receiving General Assistance will be eligible for the Disability Assistance program under the revised definition of permanent and total Disability."

It is interesting to note in the appended table that, the overall cost of Medical care has risen since 1953, the cost of physicians' services with drugs has decreased in spite of an increased case load. This fact should be especially noted by the Commission.

During the past year, Dr. Julius H. Hess of Chicago, a member of the Advisory Committee since its inception, passed away. Through the years Doctor Hess made many constructive contributions to the Committee and its work. He gave freely of his time and his great experience. His knowledge and careful consideration of the problems faced by the Committee contributed materially to whatever measure of successful work the committee accomplished. In his judgments and in his opinions, Doctor Hess was always mindful of the welfare of the residents of the State of Illinois and the recipients of assistance, as well as considerate of the members of the profession which he served so faithfully for so many years.

In conclusion, your Committee earnestly solicits the cooperation of each individual physician, in attempting to make a program function within the Boundaries established by law, and in aiding in a fair distribution of the funds available for Medical care.

In this situation you can readily see that if one physician attempts to capitalize on more than his proper share of the money available (and this is fixed amount or budget established by the Legislature) he is taking it out of his fellow physician's pocket.

The following table on the expenditures for Medical Care should be of interest to all.

Respectfully submitted,
Edwin S. Hamilton, M. D.
Harlan English, M. D.
Charles P. Blair, M. D.
Theodore R. Van Dellen, M. D.
Joseph W. Compton, M. D.
Charles Lesage, M. D.
B. E. Montgomery, M. D.
*Chairman*

*Ex-officio*:
F. Garm Norbury, M. D.
*President*
Joseph T. O'Neill, M. D.
*Chairman of The Council*
Harold M. Camp, M. D.
*Secretary*
*Advisory Committee to Illinois Public Aid Commission*

Table II.
1-24-56

Illinois Public Aid Commission
*Monthly Average Number of Patients and Amount Paid For Medical Care in The Categorical Programs by Type of Service, Total State*

| | *Jan.-June* 1953 | *Jan.-June* 1955 |
|---|---|---|
| Grand Total (Unduplicated) .... | 45,864 | 49,561 |
| Medical Only | | |
| Physician Service ..... | 18,241 | 13,945 |
| Physician Services with Drugs ..... Physician Service Drugs Dispensed | 20,747 | 19,301 |
| Hospital ..... | 3,484 | 3,472 |
| Drugs Prescribed ..... | 16,150 | 21,755 |
| Other Medical ..... | 5,150 | 10,993 |
| Nursing Home Care ..... | 9,851 | 10,993 |
| Grand Total .....$2,073,043.78 | | $2,242,388.96 |
| Medical Only ..... 1,079,839.43 | | 1,133,973.38 |
| Physician Service ..... 119,816.45 | | 117,351.89 |
| Physician Services with Drugs ..... 216,066.03 | | 173,795.79 |
| Physician Service .... 144,133.91 | | 119,261.83 |
| Drugs Dispensed .... 71,932.12 | | 54,533.96 |
| Hospital ..... 555,130.60 | | 588,164.44 |
| Drugs Prescribed ..... 101,030.01 | | 161,420.08 |
| Other Medical ..... 87,796.34 | | 93,241.18 |
| Nursing Home Care ..... 993,204.35 | | 1,108,415.58 |

## ADVISORY TO VETERANS ADMINISTRATION

To the Members of the House of Delegates:

The following statistical data representing workload during calendar year 1955 is furnished by Dr. Lee H. Schlesinger, Manager of the Department of Medicine and Surgery and Chief Medical Director of the Veterans Administration West Side Hospital:

*Fee Basis Activities*

The Veterans Administration authorized 19,793 treatments or examinations to 9,624 veterans at a cost of $91,210 to participating physicians during this period. Included in this total were treatments for 1,312 Spanish American War Veterans at a cost of $9,132.

The Home Nursing Program consisted of 10 veterans receiving 238 visits at a cost of $601.10. It is of interest to note that one of these veterans is under continuous nursing care, with visits totalling 13 per month.

*Staff Activities*

The Outpatient Clinic staff treatment or examination consisted of providing 159,546 treatments or examinations to 54,395 patients during the period reported. This included 1,446 Spanish American War Veterans.

*Contract (Non-VA) Hospitalization.*

Contract hospitalization representing private, municipal and NP hospitals, private and state, includes a total expenditure of $229,070 which represents a total of 30,302 patient days, or an average of $7.56

per patient day covering hospitalization in non-VA hospitals.

Some difficulty has been encountered in providing timely authorizations for fee basis treatments due primarily to the fact that requests for continuous treatment are not received in sufficient time to allow for administrative processing prior to the date that treatment is to be initiated. While arrangements have generally been provided to cover reimbursement for medical treatment rendered for these beneficiaries, even though there is a delay in receipt of the request form, other benefits to which the veteran is entitled; namely, beneficiary travel, may not be authorized retroactively. Accordingly, the rights of these beneficiaries to certain reimbursement funds are placed in jeopardy. Action to provide timely submission of requests for continuous treatment to allow for the normal administrative processing would be a definite service to the veteran and would be sincerely appreciated.

The over-all cooperation of the members of the Illinois State Medical Society, and each of the participating physicians under this program, has gained recognition of the high standard of medical care maintained in this area.

Dr. Schlesinger has been most cooperative with the Illinois State Medical Society, and it is pleasing to note that the Committee has no knowledge of transgression on the part of members of the Illinois State Medical Society such as has been reported elsewhere throughout the country in the daily press in connection with the rendering of care to veterans.

Respectfully submitted,

PERCY E. HOPKINS, M. D.
*Chairman*
F. LEE STONE, M. D.
*Vice-Chairman*
LEO P. A. SWEENEY, M. D.
CARL F. STEINHOFF, M. D.
HAROLD M. CAMP, M. D.
*Advisory Committee to the Veterans Administration*

## ADVISORY TO UNITED MINE WORKERS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Your committee has had 3 meetings and several conferences with the Area Medical Administrator from the office of the U M W of A Welfare and Retirement Fund during the past year.

Not too many problems have arisen. The major controversial subject has been the Directive of November 1, 1955, which limits the surgical care of U M W of A recipients to Board, Board eligible or F. A. C. S. surgeons. Many resolutions have been coming in with reference to this directive. These have been studied and brought before the council of the Illinois State Medical Society.

The council directed your committee to prepare a resolution to be forwarded to the committee on Medical care for Industrial workers of the council on Medical Service and the council on Industrial Health of the American Medical Association. This was done. The council of the State society adopted the resolution and the Secretary forwarded it as directed by the House of Delegates of the A M A at its June 1955 meeting.

Following is the resolution.

To: The committee on Medical care for Industrial workers of the Council on Medical Service and the Council on Industrial Health to the American Medical Association.

From: The Council of the Illinois State Medical Society

Whereas The District 12 Area Medical office on November 1, 1955 issued a directive (copy attached) with reference to the surgical care of beneficiaries of the fund as follows:

"1. Major surgery in all fields will be paid for only when performed by recognized specialists designated in our listing of surgeons."

and

Whereas, recognized specialists have been designated as only those certified or certified as eligible by the American Board of Surgery, and the American College of Surgeons, and

Whereas, approximately 70% of the surgery in Dist. 12 area of Illinois has been done by General Practitioner Surgeons, and

Whereas, It is the feeling of the Medical Profession of Illinois that this Directive is discriminating, and interferes with the free choice of Physicians, and

Whereas, In some instances it would require referral to a distant medical center, now therefore be it

Resolved, That the Council of the Illinois State Medical Society go on record as opposing this directive, and that this resolution be referred to the Committee on Medical Care for Industrial Workers, of the Council on Medical Service and the Council on Industrial Health of the American Medical Association as directed by the House of Delegates of the AMA at June 1955 meeting."

It is the opinion of your committee that the Fund will abide by the decision handed down by the AMA.

The problems and attitude of the Fund are discussed quite frankly in the Area Administrators report to your Committee on January 22, 1955.

The following four paragraphs are quoted from this report and are self explanatory.

"The most important matter transpiring since the October, 1955 meeting with this Committee has been our continued efforts to arrange for a high quality of hospital and medical care of coal miners and their dependents and the avoidance of waste, extravagance and dissipation of Fund resources. You are all acquainted with our November 1 letter clarifying Fund policy in particular reference to our purpose to utilize to the fullest possible extent the services of broadly competent and responsible surgeons according to criteria of the American Board of Surgery and the American College of Surgeons.

This matter has been discussed at length at each of the Committee meetings since February 1955. The necessity for limiting coverage for surgery to qualified surgeons has been recognized repeatedly by this Committee. I have sought your counsel and advice on the proper method of implementing such limitations in previous meetings. It has generally been agreed that use of the criteria established by the American Board of Surgery and the American College of Surgeons was the best available and most logical method. Although you have recognized the problem of the capable general practice surgeon, who is not certified or eligible for certification on the basis of training requirements, you have advised me against making arbitrary exceptions to the specific requirements. Recent experience emphasize the wisdom of your advice in this regard. In fact, in order to avoid being arbitrary, it will be necessary for us to request from surgeons eligible for certification but not yet certified documentary evidence from the American Board and College indicating their eligibility for examination.

The apparent reaction to the November 1 letter has, to date, been about what we had anticipated in our previous discussions of this matter. In general, there has been no evidence of disruption of services to beneficiaries. We have had no complaints from beneficiaries. We have had a few letters from physicians requesting further clarification and our answers have apparently been satisfactory. We have had a number of referrals to specialists as a result of our letter,

PERCENTAGE DISTRIBUTION OF VARIOUS TYPES OF SURGICAL OPERATIONS FOR FUND BENEFICIARIES BY TYPE OF PHYSICIAN PERFORMING THEM FOR PERIOD JAN.-MARCH 1955*

| | Board Diplomate or Other Specialist | | General Practice Surgeon | | Number of Operations | |
|---|---|---|---|---|---|---|
| | All Areas | St. Louis | All Areas | St. Louis | All Areas | St. Louis |
| Hernia Repair | 66 | 53 | 34 | 47 | 548 | 49 |
| Appendectomy | 54 | 29 | 46 | 71 | 876 | 65 |
| Cholecystectomy | 66 | 33 | 34 | 67 | 349 | 40 |
| Hemorrhoidectomy | 54 | 22 | 44 | 78 | 383 | 36 |
| Hysterectomy | 66 | 34 | 34 | 66 | 396 | 32 |
| Varicose Veins | 73 | 20 | 27 | 80 | 92 | 5 |
| Plastic Surgery | 70 | 55 | 30 | 45 | 110 | 9 |
| All Surgical Cases | 58 | 37 | 42 | 63 | 16,567 | 970 |

* Source: Statistical Department, UMWA Welfare and Retirement Fund, Washington, D. C.

(St. Louis Area Medical Office, UMWA-Welfare and Retirement Fund, 1-20-56)

indicating a spirit of cooperativeness from the doctors in the mining communities. For this we are appreciative.

In reviewing the training and experience records of physicians preparatory to publication of a Directory of Physicians with whom we have advance arrangements, we have recognized unusual situations in two mining areas. We have discussed possible solutions with the chairman of this Committee and another Committee member, both of whose areas are involved. According to information provided by the physicians currently doing surgery in these two areas, and the published requirements of the American Board and American College, the physicians do not have the required residency training for certification. Although we are prepared to arrange for necessary surgery in cities within reasonable distance for transfer of non emergency cases, we recognize that it is to the advantage of the people in any given area if the local hospital and medical services can be developed. By Fund coverage of broader hospital services in hospitals with good basic facilities for further development, the hospital is in a better position to continue improvement of its facilities and services. Certainly, the Fund would prefer to be helpful to the elements in these communities which are interested in improving and developing hospital and medical services, rather than to discourage such development by transfer of surgical cases to other facilities. As a beginning toward this goal, the Welfare and Retirement Fund is in a position to provide coverage for the consultant services of a well qualified surgeon who would be willing to visit the hospital at regular intervals and be available to the present surgical staff in a teaching role for consultation on fund cases. These plans are obviously in a preliminary stage, but would appear that they offer a good possibility of a sound solution in the further development of hospital and medical services in these areas."

The above table shows the percentage distribution of the various types of surgical operations.

It is the hope of this Committee that some satisfactory solution to this problem can be arrived at in the near future.

Respectfully submitted,

B. E. Montgomery, M. D.
*Chairman.*
James A. Weatherly, M. D.
W. W. Fullerton, M. D.
W. I. Taylor, M. D.
J. A. Mathis, M. D.
Charles Ahlm, M. D.
*Advisory Committee to the United Mine Workers.*

DR. MONTGOMERY: I have a supplementary report.

Mr. Chairman and Members of the House of Delegates: At the direction of the Council of the Illinois State Medical Society, I was requested to attend the meeting on Medical Care for Industrial Workers in Charleston, West Virginia, on Sunday, May 6, 1956. This is a meeting of a Committee from the American Medical Association with the area administrators of the Fund and Chairmen of State Society Advisory Committees, and is held each year in Charleston. The problems confronting all the states are brought before this group.

It was my privilege to appear before a closed hearing of this Committee, with reference to the resolution of the Council as noted in the Chairman's Report.

It will come out in the Reference Committee that Illinois hopes to adopt a similar plan to that in force by the State of Pennsylvania with reference to an agreement with the United Mine Workers Welfare and Retirement Fund. We would like full attendance at the Reference Committee so that we can discuss this problem thoroughly. If you have last week's issue of the Journal of the American Medical Association you will find a complete report on the Pennsylvania plan. I would like to have you study this before you come in so that we can make some disposition of this situation.

THE PRESIDENT: This will be referred to Reference Committee B on Reports of Council Committees, Dr. N. L. Sheehe, Chairman.

## LIAISON TO AMERICAN LEGION

To the Members of the House of Delegates:

Again, this past year, there was an opportunity to meet with representatives of the Veterans' Administration, The American Legion, and The American Medical Association for the purpose of discussing further the problems concerning the proper disposition of medical care of non-service connected veterans.

While no definite measurement of accomplishment can be recorded, nevertheless the goal of better understanding is somewhat nearer at hand. The distance of misunderstanding between us has been shortened because of the fact that our individual groups have been willing to meet to present their views and to listen to those of others. In such a spirit of co-

operation, better understanding is sure to follow.

The meeting was held in Indianapolis on September 27, 1955, which brought together the same interested groups from eleven States as have been meeting in Indiana since 1952. There were representatives from the medical, dental and allied professions plus the American Legion.

The "Forum" was not called "to initiate and direct action on the problems under discussion", namely, medical and dental care of veterans throughout the nation, but rather to disseminate information solely for the purpose of enlightenment. Therefore, no policies were established and no literature was distributed. The entire session was educational in nature.

Dr. Norman R. Booher, of Indianapolis, was Chairman of the Forum and Moderator of the panel discussion. The panel members represented the Veterans' Administration, The American Legion, The American Hospital Association, The American Dental Association and The American Medical Association. Illinois was represented by Dr. Walter Bornemeier, Dr. Jacob E, Reisch, Dr. Harold M. Camp and Dr. Norman L. Sheehe. Governor George N. Craig, of Indiana, was host to those attending the meeting at the Governor's Mansion at the close of the Forum.

Respectfully submitted,

NORMAN L. SHEEHE, M. D.
*Chairman.*
WALTER C. BORNEMEIER, M. D.
L. ROBERT MELLIN, M. D.
JACOB E. REISCH, M. D.
JAMES A. WEATHERLY, M. D.
*Advisory Committee to The American Legion Department of Illinois.*

## ADVISORY TO SELECTIVE SERVICE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

As in past years, the Advisory Committee has been kept very busy reviewing the cases of all physicians within the state who have not entered on active duty.

The committee has already sent a representative to talk with the June graduates of four of the medical schools, in order that they may be informed of their military liability and give information with regard to the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program.

We have not been able to recommend the essentiality of any man for residency training and this has been the policy for the past several years.

Due to budgetary conditions, the committee has been unable to hold a State Meeting as the Federal Government has made no funds available to us for travel.

The Advisory Committee assisted Illinois State Headquarters of Selective Service in reviewing the resident staffs of all hospitals and universities, endeavoring to aid Selective Service make certain that all physicians in the State of Illinois, who are in the United States under the Doctor Draft Law, are registered.

Respectfully submitted,

CARL F. STEINHOFF, M. D.
*Chairman.*
LEO P. A. SWEENEY, M. D.
JAMES MAJARAKIS, M. D.
F. GARM NORBURY, M. D.
HAROLD M. CAMP, M. D.

## ADVISORY TO WOMAN'S AUXILIARY

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Your committee, appointed by the Chairman of the Council, has worked in close liaison with the Woman's Auxiliary of this society. The relationship has been a pleasant one and it is believed that decisions made by this committee were sincere and helpful and that they were accepted gracefully and gratefully, with a knowledge by the members of the Woman's Auxiliary and of this committee that we at times spoke as representatives of the Council.

The greatest amount of committee work dealt with the Revision of the Constitution and By-Laws of the Auxiliary. At the time this report is being written the proposed changes submitted to this committee have been approved and are being printed so that they may be circulated to each county auxiliary for study prior to consideration at the annual meeting.

Approval of the proposed Constitution and By-Laws entailed careful and earnest deliberations by this committee, which had the aid and advice of AMA officials, Illinois State Medical Society officers and its legal counsel, and a nationally known parliamentarian who is the official parliamentarian of our Womean's Auxiliary.

The proposed changes are patterned after the Constitution and By-Laws of the Auxiliary of the AMA and of several of the larger states, especially of the New York State Auxiliary, with proper regard for their application in Illinois.

Your committee presents this report with pride and with the firm belief that it has, for this year, diligently completed a difficult task.

Respectfully submitted,

LEO P. A. SWEENEY, M. D.
*Chairman.*
WALTER C. BORNEMEIER, M. D.
HAROLD M. CAMP, M. D.
WILLIS I. LEWIS, M. D.

## REPORT OF WOMAN'S AUXILIARY

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Active Leadership in Community Health has been the slogan of the Auxiliary during its twenty-eighth year. This has been accomplished through thoughtful public relations work with energetic and enthusiastic participation of the majority of the members in their communities' projects.

Action taken by the council of the Illinois State Medical Society in approving the creation of an American Medical Education Foundation chairmanship in our auxiliary was deeply appreciated. Accordingly, Illinois' first A. M. E. F. Chairman was appointed at the March Board meeting. To date the aggregate sum of money for this cause is remarkable, and over $2,000 of this amount has been secured in the Third District.

BENEVOLENCE continues as the main philanthropic project of the auxiliary, according to the directives of your society. We regret that our donation—which is approximately $4.000—is considerably less than in recent years. But, with continued encouragement from the medical society, we hope this deficit will be cleared. Monies raised for Benevolence were realized through $1.00 per capita dues, hospital gift shops, bake sales, rummage sales, etc.

BULLETIN is the official publication of the A. M. A. Auxiliary. It is subscribed to voluntarily at $1.00 per subscription. This year the Illinois subscriptions were sizeably increased by the generous donation of the medical society in the Third District of 4,000 subscriptions—one for every doctor's wife in that district. The total subscriptions for the state are 4,457.

CIVIL DEFENSE programs have been stressed, and we are happy to report an increase in interest. A state-wide survey reveals that 5.27% of auxiliary homes have well equipped basement shelters, and there are 5.13% of the members participating in other civil defense activities.

LEGISLATION, one of the most important objectives of the auxiliary, has been treated with concern in every county. June 3, 1955, telegrams were sent to every county regarding the urgency of immediate action concerning Senate Bill 709. The response

was excellent. Throughout the year the county legislative chairmen have received the Washington and Springfield Newsletters, as well as timely reminders from the State Legislative Chairman. Study groups and programs have been held in many counties.

NURSE RECRUITMENT continues as the outstanding part of the program. More than 8,000 high school youngsters have been contacted with intent to interest them in Nursing, or allied medical fields. $5,070 has been contributed by the county auxiliaries for local Nurse Scholarship or Loan Funds. At least 33 Future Nurse Clubs are being sponsored by the county auxiliaries.

ORGANIZATION has been at a stand-still, but we are happy to report an increase in membership. The total membership as of March 31st, 1956 is 2663. We have 81 Members-at-Large in 36 counties, an increase of 34 members since last year. There are now only 17 counties in the state which do not have any representation.

PROGRAM has stressed good public relations as well as all the departments of our work. This year Illinois' auxiliary celebrated, along with many other state auxiliaries, National Doctors' Day, March 30th. We are grateful to the Council of the Medical Society for inviting the auxiliary to share the Tuesday evening party during the convention, at which time the doctors will be the honored guests.

PUBLIC RELATIONS has been carried out in every phase of our program. Members have, as individuals, assisted with health agency fund drives, i. e. Red Cross, Polio, Cancer, Heart, etc. Many hours of service have been given to work with crippled children, mental patients, Gray Lady work, etc. Auxiliary members have staffed TB and Blood Mobile units. One auxiliary has staffed the State Medical Society's booth at the Illinois State Fair in Springfield for many years. Other auxiliaries have cooperated with the school health programs in assisting with audio and visual tests.

TODAY'S HEALTH subscriptions are about three-fifths of the goal for our state.

MEDICAL HISTORY has been publicized in the Illinois Auxiliary News and through communications from the chairman. The counties report a total of 37 copies sold this year.

ILLINOIS AUXILIARY NEWS has been edited three times this past year. We are grateful to Mr. Web Johnston, printer, and the Medical Society for their generosity in making this publication possible.

REVISIONS have been under consideration by the joint committees—the appointed, the elected, and the Advisory, since September, 1955.

To those of you who have been so considerate and helpful the auxiliary president wishes to say THANK YOU! A special word of appreciation is extended to the Advisory Committee, Dr. Leo P. A. Sweeney, Chairman, Dr. Walter C. Bornemeier, Dr. Harold M. Camp, and Dr. Willis I. Lewis, for their advice and indulgence in considering auxiliary policies and the convention plans.

We are most grateful to the Medical Society for its material aid in providing the stationery, printing, much of the mimeographing, and especially the financial assistance of convention funds. The personnel in both the Monmouth and Chicago offices has been most cooperative. Our sincere thanks to every one of you.

This officer visited twenty-seven county auxiliaries and was constantly aware of the effectiveness of this organization at the local level—regardless of whether there were four or four hundred members present. A never-failing ingenuity and enthusiasm abounds in each group, and the auxiliary president is confident that Illinois will continue with an enviable Auxiliary record.

In closing, your state auxiliary president respectfully recommends with reference to the resolutions set out as Items 6, 7, and 8, on pages 92 and 93 of the Illinois Medical Journal for July, 1955, that this matter be left to the Woman's Auxiliary to the Illinois State Medical Society for disposition by its members at such time and under such circumstances as they deem proper. This officer believes the auxiliary is capable of taking care of all matters of this kind within the confines of its organization. The competent advisors which you have appointed have always been willing and able to take care of all situations which have been presented to them by our auxiliary.

Respectfully submitted,

Mrs. Warren W. Young,
*President.*
*Woman's Auxiliary to the Illinois State Medical Society.*

## COMMITTEE ON BLOOD BANKS

To the Members of the House of Delegates:

There were no items of business referred to the Committee on Blood Banks during the year so it was unnecessary for the Committee to have an official meeting.

In view of the financial support given by the Illinois State Medical Society to the North Central District Blood Bank Clearing House, the members of the State Medical Society should know the present financial condition of the Clearing House. As of January 31st, 1956, the assets of the Clearing House totaled $12,715.20, which included approximately $1200. worth of office furniture. The liabilities of the Clearing House at the same time were approximately $11,805.76. This did not include the $6,000. loaned to the Clearing House by the Illinois State Medical Society. It is important to note that the income of the Clearing House is derived from fees charged for transactions handled by the Clearing House. Since the Clearing House began to do business the number of monthly transactions has increased. In June 1955, the number of transactions was 222, while in January 1956 the number of transactions was 971.

Most of the transactions were from the states of Illinois, Wisconsin and Minnesota. During the past year the Michigan Association of Blood Banks was formed and on Sunday, April 8th, 1956, the Missouri Association of Blood Banks was formed. The State Associations of Blood Banks should result in a closer cooperation between the blood banks in the states and the North Central District Clearing House.

At the present time, the Clearing House is in need of additional money to facilitate a fluid cash balance in the bank. This would provide a smoother financial operation of the Clearing House. The amount of $6,000. is needed for this purpose. The Board of Directors of the Clearing House has discussed the problem with the Accountant for the Clearing House and if the Illinois State Medical Society finds it convenient to advance another loan to the Clearing House the situation would be alleviated. If on the other hand the Illinois State Medical Society does not elect to make another loan, the Medical Societies of the surrounding states will be approached for help.

Respectfully submitted,

W. A. Hause, M. D.
Benjamin Markowitz, M. D.
Paul A. VanPernis, M. D.
Albert Wolf, M. D.
Paul Reinertsen, M. D.
William M. Lees, M. D.
Paul Ross, M. D.
Coye C. Mason, M. D.
*Chairman,*
*Committee on Blood Banks.*

## ADVISORY TO OCCUPATIONAL THERAPY ASS'N.

To the Members of the House of Delegates:

This committee has met once, namely, April 5, 1956, at the request and in the presence of a group of six women who are leaders in the Occupational Therapy organization in the state of Illinois. Their names are: Miss Fay, County Hospital; Miss Britton, Rehabilitation Institute; Mrs. Jameson, Crippled Children's Organization (Easter Seal Group); Miss Clement, Research Hospital; Miss Wade, Research Hospital; Miss Hoffman, Winfield Sanitarium.

The entire committee composed of Drs. Rodriquez, Kendall, Jensen, and myself were present.

No action was taken by the committee which properly should come to the attention of the House. The OT group pointed out that they needed guidance in dealing with their problems. Their problems involve acceptance within hospitals, acceptance within the community, proper utilization of their special talent which means training doctors to learn what they can do and apply it in a timely manner, subject matter for curriculum for schools of Occupational Therapy, in organizational matters and the like. The group of Occupational Therapists requested that they have the privilege of approaching members of the Advisory Committee individually for advice informally and of having the committee meet twice yearly. The committee approved such a procedure. No date was set for the next meeting, however. The group of occupational therapists believes that pediatrics, tuberculosis, and orthopedics might be represented on the committee in the future.

Respectfully submitted,
Arthur A. Rodriquez, M. D.
Louis Jensen, M. D.
H. Worley Kendall, M. D.
Ford K. Hick, M. D.
*Chairman,*
*Advisory Committee on Occupational Therapy.*

## CANCER CONTROL

To the Members of the House of Delegates:

Intense interest in chemotherapy of cancer continues; progress is slow but new chemicals are being tried in numerous laboratories, particularly on animals.

At a recent meeting of our Committee numerous activities in cancer throughout the country were discussed. A recent report from the Memphis group which obtained vaginal smears from 70,000 women and found 540 cases of uterine or cervical cancer was very revealing and our Committee expressed its hearty approval of the smear method of diagnosis. Our Committee discussed various methods of intensifying interest in cancer throughout the state, and agreed we might devise mechanisms of creating more interest in the various cancer clinics throughout the state, particularly by having cancer "experts" visit them. Such a problem would involve contact with the clinics themselves, Dr. Gowan's Division in the State Department of Public Health, and the Postgraduate Committee of the Illinois State Medical Society.

Our Committee reaffirmed its hearty approval of lay education in cancer, and in particular expressed the belief that films like "Self-Examination in Cancer", were very effective in getting patients with cancer to the physician early.

The Committee acted favorably upon a request from Dr. DuPuy, of Quincy, to lend assistance in a television program, sponsored by the Adams County Medical Society, April 15th, coinciding with the Cancer Drive. Dr. Majarakis was appointed moderator of a panel of four physicians from Quincy to prepare a program for the telecast. The Committee heartily approves such telecasts and expressed willingness to help out other local medical societies in any way possible.

During the year our Committee prepared a letter calling attention to certain activities in cancer; this letter was sent out to the physicians of Illinois by Dr. Rogers, of the Illinois Division of the American Cancer Society.

Dr. John Rogers continues as Director of the American Cancer Society, Illinois Division, and has submitted information below concerning activities of the Division.

"Last year, $1,258,738 was collected throughout the state for American Cancer Society activities. Forty per cent of this goes to the National office, in New York. Of the sixty per cent kept here, thirty-five per cent was devoted to cancer research, twenty-three per cent to service to cancer patients, fifteen per cent to public and professional education, and only 2.8 per cent to administration.

"The research program of the Illinois Division has continued to expand. In 1953, $47,560 of Illinois funds was expended. In 1954 this was increased to $71,200. During the fiscal year ending August 31, 1955, this has jumped to $100,178. This large amount of money went to 18 individual investigators at nine Illinois research institutions. Each of these grants was very carefully considered by our Research Committee, was subject to an additional scrutiny by our Medical and Scientific Committee, and finally approved by our Board of Directors or Executive Committee. Many other requests for research funds were disapproved for one reason or another. During the past year, $78,383.93 has been received from legacies. As a policy, these funds are expended for cancer research projects because it is felt that most persons leaving us money would like to have it spent in that manner, as in most instances, cancer was the disease which killed them. Our national organization has, of course, continued to make the great bulk of research grants from money that they receive from state divisions. Much of this, too, found its way to Illinois, and actually exceeded the money which we forwarded to our national organization.

"The fifteenth cancer refresher course for physicians was held in February 1955, and the sixteenth in February 1956. This course is of three days' duration and covers cancer in most portions of the body. Some 55 downstate physicians attended each meeting and a number from the Chicago area. The class was transported to Northwestern University Medical School, the University of Illinois College of Medicine, Mercy Hospital (Stritch School of Medicine, Loyola University), Michael Reese Hospital and the University of Chicago Medical School. The stress in this course is on early diagnosis and the most modern methods of treatment.

"We have continued providing fellowships for the training of five young physicians at the Illinois Education and Research Hospitals and one for the tumor clinic at Presbyterian Hospital.

"The two cancer bulletins, known as "The Cancer Bulletin", published in Texas, and "CA, A Bulletin of Cancer Progress", have been provided free throughout the year to 4,250 physicians. During the latter part of the fiscal year the circulation was increased to 4,800. These are excellent publications, containing the latest available information, compiled from scores of medical journals, and are well received and appreciated by the recipients.

"The Division possesses a considerable library of professional films from which films were provided for 124 medical meetings.

"The Division sponsored a program for members of the *dental profession,* prepared by our Dental Education Committee, and held at the University of Illinois College of Dentistry in June. Through the cooperation of the Illinois State Dental Society, this program was circulated to all of the dentists in Illinois and was so popular that some 300 applications had to be denied because of lack of space. Over 200 attend-

ed the one-day session devoted to cancers in the region of the head and neck, with particular emphasis on the oral cavity, from the point of view of early recognition by the dentist and referral for proper treatment.

"In April, a program of two days' duration was conducted for 182 *industrial nurses*. There are some 900 graduate nurses employed by industries and business in Illinois. These women are in an unusually strategic position to give positive health information to thousands of workers who are employed in plants, shops and offices. The program content of the symposium gave them up-to-date knowledge about cancer, its diagnosis and treatment, the service program of the Illinois Division, and the methods and materials for them to use on the job in giving life-saving facts on cancer."

Dr. G. Howard Gowen continues as Deputy Director of the Division of Hospitals and Chronic Illness of the State Department of Public Health. Below is given a summary of activities of his Department for the past year.

"Financial support of diagnostic services in twenty-seven cancer clinics. There were 3,811 patients examined for suspected cancer, of which 1,361 were proved to have malignancy. There were 5,830 followups of previous cases. As part of the tissue diagnostic service for patients unable to pay, 3,397 biopsy specimens were submitted for examination. In addition, eighty-six specimens were submitted for cytological examination.

"The central case registry continues to accumulate statistical data obtained from case reports made by cancer clinics and cancer registries in general hospitals. There are now 20,373 case reports on file. It is planned in 1956 to issue a published statistical study of these cases.

"Upon recommendation of the Advisory Board to the Bureau of Cancer Control, a communication was sent to all State-supported cancer clinics in which questions were asked regarding function of the clinics. Based on the answers received, it would appear that the clinics are still considered to be important local resources but are not supplying their maximum potential service as a means of postgraduate education. In order to stimulate this phase of activity, it was recommended to the directors of all the cancer clinics that two or three times a year formal programs be conducted to which outside speakers would be invited, annual reports be prepared of clinic activities and distributed to members of the local county medical society, local members of the Academy of General Practice be informed that attendance at such clinic session can be applied as Category II (informal) postgraduate credit, and that the clinic activities be publicized more generally among the medical and dental professions.

"In cooperation with the St. Clair Medical Society, the St. Clair County Chapter, Illinois Division, American Cancer Society, the medical and administrative staff of Christian Welfare Hospital, East St. Louis, and the East St. Louis Health Department preliminary plans were made to expand the activities of the cancer clinic at Christian Welfare Hospital to include a community cytology service. As far as is known this is the first program of this sort started in the State of Illinois on a community-wide basis."

Respectfully submitted,

WARREN H. COLE, M. D.
*Chairman.*
CAESAR PORTES, M. D.
EDWIN F. HIRSCH, M. D.
CARL E. CLARK, M. D.
RUSSELL M. JENSEN, M. D.
JAMES MAJARAKIS, M. D.
JOSIAH J. MOORE, M. D.
PATRICK MCNULTY, M. D.
AUGUSTA WEBSTER, M. D.

## CARDIOVASCULAR DISEASE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Members of the committee have talked informally during the year and all members have been reached by correspondence. There have been no pressing new problems in the area.

The Illinois Heart Association and the Chicago Heart Association have been increasingly active in the fields of professional and lay education, community service and research. The Illinois Public Health Service continues its excellent service to the public and the profession in cardiovascular disease.

The committee reiterates its recommendation of last year with respect to the desirability for our society to take leadership in the field of rehabilitation. Patients with cardiovascular disease do not enjoy adequate facilities and neither the patients nor their physicians have a broad enough understanding of the possibilities of rehabilitation. However, this committee feels that this situation should not be corrected through the establishment of new centers devoted entirely to cardiac patients, but rather through the expansion and coordination of present rehabilitation facilities. Most of these agencies do very little work in the field at present.

The Council of the State Medical Society has been apprised of this recommendation of the committee but has not acted as yet.

Our Society is well situated to take leadership in the study of rehabilitation facilities and needs, in increasing the facilities for cardiac and other patients, and in educating physicians and patients in the advantages of formal efforts in the field of rehabilitation.

Respectfully submitted,

WRIGHT ADAMS, M .D.
*Chairman.*
WARNER H. NEWCOMB, M. D.
*Co-Chairman.*
GEZA DE TAKATS, M. D.
JAMES A. WALSH, M. D.
WARREN F. PEARCE, M. D.
ANGELO P. CRETICOS, M. D.
*Committee on Cardiovascular Disease.*

## JOINT COMMISSION FOR IMPROVEMENT OF CARE OF THE PATIENT

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

This commission was approved by the sponsoring organizations and a code of administrative regulations was agreed to on March 14, 1956 by the sponsoring organizations.

Illinois State Medical Society
Illinois Hospital Association
Illinois State Nurses Association
Illinois League for Nursing

The purpose of the commission is to stimulate, implement, assist in, and sponsor activities which will contribute to care of the patient as may be mutually satisfactory to the participating organizations.

Officers of the Commission will be elected once a year and the chairmanship rotated among the three professions represented. It includes four appointed members from the state medical society and the hospital association, and two each from the nurses' association and the league for nursing. The presidents and secretaries of each of the four participating groups sit as ex-officio members of the commission. The group elected Dr. Karl S. Klicka chairman, Mrs. Louise A. Meyer, vice-chairman, and Dr. Maurice M. Hoeltgen, secretary for the year 1956.

The voting members of the commission are:

Representing the Illinois League for Nursing:

Miss Gladys Kiniery dean, School of Nursing, Loyola University, Chicago
Miss Ann Lucille Lard, director of nursing, U. of I., Chicago

Representing the Illinois State Nurses Association:
Mrs. Renetta Healy, director of nurses, East Side Health Dept., East St. Louis
Mrs. Louise A. Meyer, director of psychiatric nursing facilitation program, Jacksonville State Hospital, Jacksonville
Representing the Illinois Hospital Association:
Dr. Karl S. Klicka, director, Presbyterian Hospital, Chicago
Dr. Stephen Manheimer, director, Mount Sinai Hospital, Chicago
Leon C. Pullen, Jr.. administrator, Decatur and Macon County Hospital, Decatur
Rev. John Weishar, director of Catholic Hospitals, Diocese of Peoria, Peoria
Representing the Illinois State Medical Society:
Dr. Everett P. Coleman, Canton
Dr. Maurice M. Hoeltgen, Chicago
Dr. Patrick McNulty, Chicago
Dr. William H. Schoengerdt, Champaign

The representatives of the Illinois State Medical Society would appreciate receiving problems from our society and from members that might be discussed by the commission and taken back to the sponsoring organizations for action.

Respectfully submitted,
EVERETT P. COLEMAN, M. D.
MAURICE M. HOELTGEN, M. D.
PATRICK MCNULTY, M. D.
WM. H. SCHOENGERDT, M. D.
*Joint Commission for Improvement of Care of The Patient*

## CONSTITUTION AND BY-LAWS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The following amendments are offered for consideration:

1. Amend Article V of the Constitution entitled "House of Delegates" by deleting section (c) "Ex-officio, the president, president-elect, vice- presidents, and the secretary-treasurer of this Society" and substitute the following: (c) "The President, president-elect, vice-presidents, past-presidents, and the secretary-treasurer of this Society, as ex-officio members without the right to vote."

This amendment, which adds past-presidents to the ex-officio members of the House of Delegates, has been approved by the Council.

2. Tenure of office is not provided for members of the Committee on Medical Service and Public Relations. Chapter IX, Section 3 of the By-Laws. It is recommended that appointments be for three years and staggered with original appointment of two for three years, two for two years and one for one year. It is proposed to amend Chapter IX, Section 3, the last sentence of paragraph 1 to read as follows: "Members of this Committee shall be appointed by the Council for terms of three years; at the time of initial appointment, however, terms should be staggered with two appointed for three years, two for two years and one for one year."

3. There is no provision for appeal from County Medical Society Grievance Committee decisions as suggested in the A. M. A. Guide for Medical Society Grievance Committees. It is proposed to amend Chapter IX, Section 8 of the By-Laws by adding paragraph (5) to the functions of the Grievance Committee as follows: (5) The Committee shall be empowered to review the actions and decisions of County Medical Society Grievance Committees when a party to a grievance complaint makes such an appeal. Appeal to this Committee is the privilege of such parties and they shall be so notified at the time of the hearing of the original complaint.

Respectfully submitted,
WARREN W. FUREY, M. D.
*Chairman.*
O. W. REST, M. D.
ARTHUR F. GOODYEAR, M. D.
JACOB E. REISCH, M. D.

DR. FUREY: According to the constitution and by-laws it is necessary to read the Amendments in addition to publishing them in the HANDBOOK. I also have a supplementary report as follows:

Amend Article IV, Section 3, titled "Emeritus Members" by adding:

"Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years."

This was approved by the Council and the Committee, Drs. O. W. Rest, A. F. Goodyear, J. E. Reisch, and W. W. Furey.

THE PRESIDENT: This supplementary report will be referred to Committee "C" on Reports of Council Committees, Dr. John R. Wolff, Chairman.

## CRIPPLED CHILDREN'S CLINICS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Crippled Children's Clinics are established in all parts of the State. Their locations are accessible to most of the patients.

Clinics are held usually at regular intervals. Lay organizations take an active interest in these clinics and give assistance in advertising the time of the clinic and assisting with the clerical work. Satisfactory hospitalization and surgery can be carried out as need arises without prolonged delay.

At the 1955 meeting of the Illinois State Medical Society of the Crippled Children's Clinic Committee, members voiced the lack of sufficient local advertising of the dates of these clinics. Many doctors would appreciate knowing beforehand. The attendance at these clinics by members of the local Medical Societies is appreciated and their assistance and advice is helpful.

Helpful and beneficient organizations are extending their services and aid thruout the State, These include the National Foundation for Infantile Paralysis, The Crippled (Easter Seals), The Illinois Elks Association, the Illinois Association, Division of Services for Crippled Children, The Shriners Crippled Children's Organization, and others.

The principal organizations holding clinics thruout the State are:

*The Elks Association*: A total of 63 clinics were held downstate during 1955, with an average of 18 children per clinic. This number does not include Danville Clinics held under combined auspices of Elks and Division of Services for Crippled Children, nor does it include hundreds of patients examined and hospitalized under the Elks program at the U. of I. Research and Educational Hospitals as a result of these clinics and emergency referrals.

*Division of Services for Crippled Children*: University of Illinois. 196 Crippled Children's Clinics were held thruout the downstate area during 1955, with a total attendance of 9,927. 16 Cerebral Palsy Clinics were held in Springfield and Rock Island with a total of 293 patients. 49 Rheumatic Fever Clinics were held in Alton, Chicago Heights, Effingham and Elmhurst with a total attendance of 811.

Of the number of Crippled Children's Clinics in Chicago that are known to function, the following are those who responded to our request for information.

*Northwestern Medical School*: Three orthopaedic clinics are held weekly, with an average of 3-4 crippled children at each clinic.

*The University of Chicago*: Eight weekly clinics are held with an approximate number of children seen per clinic: 8-12.

*Mount Sinai Hospital*: No specific figures are kept on visits made by so-called crippled children.

*The Children's Memorial Hospital*: Two weekly clinics are held with an approximate number of 40-45 crippled children seen at each clinic.

*Shriners' Hospitals for Crippled Children*: Clinics are held on Wednesdays and Fridays of each week with an average of 70 children seen.

*Michael Reese Hospital*: Children's Orthopaedic Clinics are held twice weekly with an average of 9.9 children seen per clinic.

*University of Illinois*: Ten weekly clinics are held with an average of 15-20 crippled children seen per day.

*St. Luke's Hospital*: Three clinics were held per week with an approximate number of 5 individuals treated at each clinic.

*The Presbyterian Hospital*: One clinic is held weekly for crippled children with an average of 22.7 visits per month.

*Cook County Hospital*: Six weekly clinics are held with an approximate number of 2,445 children served for year of 1955. 341 new children are registered in Orthopaedic Clinics.

The clinics in Chicago all have adequate hospital connections and many are held in Institutions which have medical school associations. This arrangement facilitates the proper care of the crippled child from the time he is first seen; thru his period of hospitalization, and finally thru his post-operative care.

A luncheon meeting for the members of the Crippled Children's Clinic Committee is planned on the occasion of the Illinois State Medical Society Annual Meeting.

Respectfully submitted,

FRANK G. MURPHY, M. D.,
*Chairman*

HUGH COOPER, M. D.
JOHN J. FAHEY, M. D.
HERBERT R. KOBES, M. D.
GERARD N. KROST, M. D.
JAMES J. CALLAHAN, M. D.
*Crippled Children's Clinic Committee*

## TO INVESTIGATE CORONER'S OFFICE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Senate Bills 247 and 248 introduced by Senator Albert Scott of Canton and offering revisions of the archaic Coroner's Act of 1874, passed the Senate by a vote of 29 to 5, and on the final day of the last General Assembly, June 30, 1955 were voted through the House of Representatives 94 to 7 and 94 to 6, respectively. Members of the Illinois State Medical Society, representatives of the Illinois Coroners Association, and advisors from the Illinois Department of Public Health had met in preliminary discussions and joined their conclusions in the final draft of these bills.

Senate Bill 247 defined more clearly the cases of death that belong to the jurisdiction of the Coroner; it specified coroner's juries only for cases of suicide, homicide, and accidental death; and it provided that the medical examinations be made by physicians licensed to practice medicine in all of its branches, and wherever possible with special training in pathology. It did not require that these physicians be certified pathologists.

Senate Bill 248, a companion to Senate Bill 247, afforded assistance to the coroner of each down-state county in securing a qualified physician to make the medical examination of his cases. It did so by arranging for these appointments through the Director of the State Public Health Department in consultation with the elected Coroner of a down-state county. Coroners and the Director of Public Health, in this plan, could thus cooperate in improving the medical examinations of coroner cases through the State, and groups of counties would benefit where each alone could have difficulty to obtain a qualified examiner. Senate Bill 248 further included the appointment of an Advisory Board by the Governor to advise the the Director of Public Health and the coroners of the counties in the development and improvement of this service. This Advisory Board of nine members was constituted to include three physicians, three elected coroners, and three laymen acquainted with the problems of forensic medicine.

Governor Stratton on July 7th signed S. B. 248, but later vetoed S. B. 247. The Illinois State Medical Sociey, other Medical organizations and lay groups were disappointed with his veto. This veto was on the basis that "a number of pathologists who would not ordinarily be employed by the coroners would be placed on county payrolls by appointment through one of the State departments. The result would be effectively to destroy county control over the cost and expense of the coroner's office." This interpretation, however, is not in full agreement with the specific directives covering the qualifications and appointment of coroner's physicians in S. B. 247. The details of this agreement are mentioned in the appended answer to the governor's friendly letter containing his veto message.

After Senate Bills 247 and 248 had been approved by the General Assembly, the following three letters were exchanged in correspondence with Governor William G. Stratton:

JULY 1, 1955

Honorable William G. Stratton,
Governor of the State of Illinois,
Springfield, Illinois.

Dear Sir:

On behalf of the Illinois State Medical Society I am writing this letter to urge that you give favorable consideration and approval to Senate Bills 247 and 248. These Bills were passed by the House of Representatives on June 30th, and have been sent to your office. The bills propose a much needed revision of the Coroner's Act of 1874, since when no sections of consequence have been added to the Statutes.

Senate Bill 247 defines more clearly the cases of death that belong to the jurisdiction of the Coroner; saves money for Counties by requiring coroner's juries only in cases of suicide, homicide or accidental death; improves the quality of postmortem examinations throughout downstate Illinois by using doctors trained for this work.

Senate Bill 248 enables the Illinois Department of Public Health to assist Coroners in the conduct of their investigations and provides an Advisory Board appointed by the Governor to advise and improve the quality of these services. The Advisory Board can suggest to the Department of Public Health procedures for the correction or adjustment of difficulties that opponents of these Bills have mentioned. Counties with adequate facilities are not affected by these Bills, except that opportunity for improvements are offered.

The members of the Illinois State Medical Society believes that Senate Bills 247 and 248 contain some of the most significant legislation in medicine and community health that has happened in Illinois. They urge your careful consideration and endorsement of these Bills.

Sincerely yours,
(s)
Edwin F. Hirsch, M. D.
Chairman of the Committee on
Revision of the Coroner's Act,
Illinois State Medical Society

August 8, 1955

Dr. Edwin F. Hirsch
Illinois State Medical Society
1439 South Michigan Avenue
Chicago, Illinois
Dear Doctor Hirsch:

Thank you for your letter relative to Senate Bills 247 and 248. As you undoubtedly know, I approved No. 248 on July 7, 1955. However, I found it necessary to veto No. 247. The enclosed copy of my veto message explains my reasons for doing so.

With appreciation for your interest and kind regards.

Sincerely yours,
(s)
William G. Stratton
Governor

WGS:ms
Enclosure

August 12, 1955

The Honorable William G. Stratton,
Governor of Illinois,
State Capitol Building,
Springfield, Illinois.
Dear Governor Stratton:

Thanks kindly for your letter of the 8th inst. relative to Senate Bills 247 and 248. The Illinois State Medical Society is pleased indeed that you approved Bill 248 on July 7, 1955. At the meeting of the Council of the Illinois State Medical Society on Sunday, August 7 at the Sherman Hotel in Chicago all of the members voiced a feeling of regret that you deemed advisable a veto of Bill No. 247. A similar feeling had been expressed on an earlier date at a meeting of the Board of Governors of the Institute of Medicine of Chicago. These expressions of feelings occurred because so much potential good of Senate Bill 247 had been lost on the basis of certain possible hazards which the drafting groups had considered but which no one believed would constitute a serious obstacle.

Your veto message stated in part:

"This Bill involves a fundamental change in the powers of the Coroners. The result will be to place upon the county payroll by appointment through one of the State Departments a number of pathologists who would not ordinarily be employed by the coroners. The result would be effectively to destroy county control over the cost and expense of the Coroner's office. Because of the fundamental departure from the existing law, this subject demands further consideration by the General Assembly."

It is fair to say that all of the provisions contained in both Bills 247 and 248 came as the result of discussions and pooled experiences of representatives of the Illinois State Medical Society, of the Illinois Coroners Association and of the Illinois Department of Public Health. All groups realized the presence of great defects in the present Coroner's Act which dates back to 1874, and especially in the quality of the medical examinations of coroner cases which everyone, lay and professional, agrees is in the field of medicine.

In order to help the Coroners of the many counties of Illinois in this respect, and to enable all downstate counties to have at least some of this professional benefit, only the minimum requirement for professional skill in necropsy examinations was specified with the hope that a modest beginning would initiate a growing service which in time the State of Illinois could look upon with respect and pride.

The specifications for the Coroner's physician performing these functions as set forth in Sec. 10.1 on page 4 of Senate Bill 247 read as follows:

"Any medical examination or autopsy conducted pursuant to this Act shall be performed by a physician duly licensed to practice medicine in all of its branches and *wherever possible* by one having special training in pathology. In Class I counties (Cook) such medical examinations or autopsies shall be performed by physicians appointed or designated by the coroner and in Class II counties (downstate) by physicians appointed or designated by the director of the Department of Public Health," and in amendment 4, "In making such appointments or designations the director of the Department of Public Health *shall consult with the elected coroner in each county.*"

None of these provisions orders the use of pathologists as specialists for the necropsy examinations. They only say that wherever possible, physicians with special training in pathology be used, and state clearly that these appointments or designations of physicians to make the necropsy examination be through the Director of Public Health in *consultation with* the elected coroner in each county. The purpose of this plan was to use well qualified physicians for groups of counties where individual coroners might have difficulty in obtaining this service.

When the Coroner's Act was placed on the statutes in 1874 modern scientific aids in the detection of the cause of unnatural deaths had not been developed. The Institute of Medicine of Chicago for more than 25 years has urged legislative improvement of the old Coroner's Act of 1874, and in this effort more recently was joined by the Chicago Medical Society, the Illinois State Medical Society, the Illinois Coroners Association, Welfare Council of Metropolitan Chicago, and other civic organizations.

Inasmuch as you have signed Senate Bil 248 which provides for the appointment of an Advisory Board on Necropsy Service to Coroners in the Department of Public Health, the Illinois State Medical Society and other interested groups earnestly hope that you will appoint soon the members of this Board. This Advisory Board can then investigate thoroughly and make suitable proposals to clarify phases of this service that now seem in doubt. You will receive presently suggestions as to qualified physicians for appointment to this Board from the Chairman of the Council of the Illinois State Medical Society through the Director of the Department of Public Health. The Illinois Coroners Association also is expected to submit suggestions for your consideration.

An Advisory Board composed of physicians, coroners and lay members, working together, can help realize great improvements in the administration of criminal and social justice in the State of Illinois.

May I thank you again for your kind letter.

Sincerely yours,
(s)
Edwin F. Hirsch, M. D.
Illinois State Medical
Society

The comments and the three letters are a statement to the members of the Illinois State Medical Society from the Committee on Revision of the Coroner's Act. The Committee hopes that Governor Stratton will appoint promptly the Advisory Board authorized under the provisions of Senate Bill 248, and that this Board will investigate and clarify questions that can make possible proposals of legislation even better than those contained in Senate Bill 247.

Respectfully submitted,

Edwin F. Hirsch, M. D.
*Chairman.*
Samuel Levinson, M. D.
Harlan English, M. D.
C. Paul White, M. D.
Franklin J. Moore, M. D.
*Ex-officio.*
Mr. John W. Neal
Mr. Walter Oblinger

## DIABETES

To the Members of The House of Delegates:

The present chairman of the Committee on Diabetes was appointed November, 1955. Since that time there has been no meeting of the Committee on Diabetes.

1. The Committee can report that the display booth on Diabetes set up at the Illinois State Fair by the Department of Public Health gave out 4,115 dry pack kits and further tested 210 on the site. Of the 315 dry packs returned and the 210 tested at the display there were 23 positive tests. The individuals were notified of the results. There has been no follow-up.
2. During Diabetes Detection Week in Peoria County, 12,000 dry pack kits were dispensed. The results have not been tabulated.
3. In Adams County in 1955, 2,892 individuals were screened for melituria and there were 55 positive, of which three were known diabetics. Again there was no follow-up.
4. In LaSalle County during the month of April, 1956 the State Mobile Chest X-ray Unit will provide each individual who applies for a chest x-ray with a dry pack kit.
5. In November, 1955, 441 individuals were screened in Sangamon County and, of these, 2 gave positive results.

Respectfully submitted,

Thomas D. Masters, M. D.
*Chairman.*
Arthur R. Colwell, M. D.
George M. Parker, M. D.
Henry T. Ricketts, M. D.
*Committee on Diabetes.*

## EDUCATIONAL COMMITTEE

To the Members of The House of Delegates:

One hundred and fifty-two physicians, one dentist, one health educator and one nurse cooperated in the activities of the Educational Committee during the period covered by this report.

TELEVISION:

The Committee has not returned to television on a regular basis. One program was produced in the experimental series on WTTW, Channel 11, September 23, 1955. Subsequently, because of the crowded programming of the station, a definite series was abandoned. However, in April news was received from the station that if a thirteen week script schedule could be set up, consideration would be given to launching a regular series.

"All About Baby," the television program for which the Committee scheduled physicians to appear weekly, went off the air in October for lack of sponsorship. Present plans are being made to obtain new commercial interests for television or, possibly, radio.

RADIO:

"Your Doctor Speaks," the transcribed series sponsored on FM Station WFJL, has been presented consistently. Only one prepared manuscript was rejected by the Committee and this only because of the controversial aspect of the subject matter. The author was asked to rewrite the material, but, thus far, has failed to do so.

SPEAKERS' BUREAU:

Included among the organizations requesting speakers were Woman's Auxiliaries, Parent-Teacher Associations, Y. W. C. A., Y. M. C. A., Women's and men's clubs, church groups, Illinois Federation of Women's Clubs, health councils, the Licensed Practical Nurse Association, Brokaw Hospital Board of Trustees, and school assemblies.

Numerous letters were received from the respective program chairmen praising the speaker's presentation and the services of the Educational Committee.

HEALTH TALK:

HEALTH TALK is released weekly in mimeographed form to the press and to officers of both the state and county medical societies. The total is 1,010. With the February 15, 1956 mailing for the monthly list, the plan to send only one issue each month to health educators, schools, nurses and industrial plants was inaugurated. This was done to effect a saving in printing charges. The individual nameplates, including schools, on the monthly list total 3,197. Members of the Chicago Chapter of the American Women in Radio and Television are in this group.

A "special" list, that is one involving special handling because of the number of issues, includes twelve individuals receiving 489 HEALTH TALK for distribution; ten schools, 431; sixty Health Improvement Associations, 1,271; eighty-nine home bureaus, 2,064, and forty-two Welcome Wagon hostesses, 3.396.

Because all reports are being streamlined this year, detailed figures will not be submitted on the several hundred issues of HEALTH TALK that were mailed on request to individual program chairmen for distribution at their respective meetings.

Blueprint for Health, Blue Cross Publication, in one volume, used two issues, "Laughter and Health" and "Laboratory Tests," and in another volume one on "Frostbite." The Banner, a Catholic magazine, reproduced the HEALTH TALK on "Help for the Spastic Child."

One person wrote that she had a cure for psoriasis. Her letter stemmed from HEALTH TALK on the subject in the Wauconda Leader.

Requests for HEALTH TALK are steadily being received from other states, but these are not filled.

MISCELLANEOUS:

The Secretary of the Committee continues her service to the Scientific Service Committee, Committee on Medical Economics and prepares the News of the State for the Illinois Medical Journal. In addition to fulfilling these obligations and those of the Educational Committee, she also rendered service to some physicians, by preparing speech material and committee reports.

The Secretary developed a special bibliography and display for the Woman's Auxiliary's Conference on Community Leadership in Chicago, October 6, and attended the following meetings: Tri-State Hospital Association (as a program participant), PR Conference of the American Medical Association, Medical Society Executives Conference, Illinois Dietitic Association, the National Society for the Prevention of Blindness, the Illinois Woman's Press Association, and the Chicago Chapter of the American Women in Radio and Television. In addition she addressed the Woman's Auxiliary of the Cook County Physicians Association and the Chicago Branch of the Chicago Association of College Women, both Negro groups. She also talked to the Training Class of Welcome Wagon hostesses, and was named a member of the Exploratory Committee on Nursing Careers of the Illinois League of Nursing.

The Committee, which by mail or telephone reviews all material directed to its attention, held one meeting, February 28. Its Chairman has submitted reports to all Council meetings.

The Educational Committee is appreciative of the continued confidence of the Council to whom it expresses its gratitude. The Committee wishes, too, to thank this House of Delegates for its unfailing trust.

Respectfully submitted,

Charles P. Blair, M. D.
*Chairman.*
Karl L. Vehe, M. D.
*Co-Chairman.*
George V. Byfield, M. D.
Harlan English, M. D.

Joseph T. O'Neal, M. D.
Lester S. Reavley, M. D.
William Whiting, M. D.
Ann Fox,
*Secretary.*

## ETHICAL RELATIONS

To the Members of The House of Delegates:

There have been no cases referred to this Committee for action during the past year.

Respectfully submitted,
Charles Allison, M. D.
*Chairman.*
V. B. Adams, M. D.
Raleigh C. Oldfield, M. D.
*Committee on Ethical Relations.*

## FIFTY YEAR CLUB

To the Members of The House of Delegates:

Since its organization eighteen years ago more than one thousand physicians have been inducted into the Fifty Year Club. Due to accidents and the infirmities of age quite a number drop out every year, and the new members are admitted. During the past year two members of the Fifty Year Club Committee passed away—Drs. Julius Hess and Edward Oschner. At present we have approximately five hundred and twenty five members. Each year every member is invited and urged to attend a noon day luncheon during the State Medical Meeting. Notwithstanding the advanced age of the members nearly one hundred were present last year, and with invited guests there were a total of one hundred twenty present. Some came from distant states to meet and greet their old comrades. This is the first Fifty Year Club organized in the United States. Since its organization several states have followed suit. Our guest speaker last year was the Dean of Medicine in the Chicago University. This year our guest speaker will be Dr. Young, Dean of the Medical Department of the Northwestern University. According to the latest report of Dr. Camp our membership is

| | |
|---|---|
| Chicago | 202 |
| Down State | 278 |
| Total | 480 |

Respectfully submitted.
Andy Hall, M. D
*Chairman.*
Ernest E. Davis, M. D.
*Fifty Year Club Committee.*

## INTERPROFESSIONAL RELATIONS

To the Members of the House of Delegates:

Members of the Interprofessional Council consist of the following healing arts groups:

Illinois State Medical Society
Illinois State Dental Society
Illinois Optometric Society
Illinois Pharmaceutical Association
Illinois Veterinary Medical Association
Illinois Association of Chiropodists

Representatives of these groups meet monthly and discuss mutual problems of interest to all of the professions.

During the past year much interest has been shown on the progress of state and national legislation. All of the members of the professions are highly appreciative of the efforts of Walter Oblinger, our assistant legal counsel, in their behalf.

Branches of the Interprofessional group are being organized at either the county or district of the Chicago Medical Society level.

The annual meeting of the Interprofessional Relations group was held at the Congress Hotel on November 7, 1955, during which time Mrs. Bernice T. Van der Vries, representative from the Suburban Cook County area was given a plaque "in recognition of her legislative service to the people of Illinois for the betterment of the health and welfare of the population."

The role of the Interprofessional Council has been widely discussed during the past year by the Council and the House of Delegates of the Illinois State Medical Society. Because some members felt that we could not associate with some of the other professions on many of our mutual interests, the entire matter of the Interprofessional Council was referred to the Judicial Council of the American Medical Association. Under date of April 4, 1956, the Executive Secretary of the Judicial Council of the American Medical Association, Mr. Edwin J. Holman, writes:

"The Judicial Council at its meeting held here in Chicago March 22 and 23 carefully considered your correspondence of January 9 concerning the membership of the Illinois State Medical Society in the Illinois Interprofessional Council.

"The Judicial Council, after careful consideration of the statements made in your letter, unanimously agreed that in its opinion, the Illinois Interprofessional Association is a political or legislative body as distinguished from a purely professional body, and that therefore the associations or relationships which obtain among the several members on the Interprofessional Council are not professional associations or consultations as contemplated in Chapter II, Section 1 of the Principles of Medical Ethics.

"It is the consensus of the members of the Judicial Council that the participation of the Illinois State Medical Society as a member of the Interprofessional Council is not contrary to the spirit or intent of the Principles of Medical Ethics."

I am sure that with this decision the work of the Interprofessional Council will continue in an accelerated pattern during the coming year.

Respectfully submitted,
E. A. Piszczek, M. D., M. P. H.
*Chairman.*
F. Lee Stone, M. D.
*Co-Chairman.*
Wayne B. Slaughter, M. D.
Myron M. Hipskind, M. D.
George B. Callahan, M. D.
Leroy Fatherree, M. D.
Julius Kowalski, M. D.
*Interprofessional Council.*

## INDUSTRIAL HEALTH

To the Members of the House of Delegates:

The continuing work of this Committee has been directed toward the formulation and implementation of a program to improve medical relations and to elevate the standards of medical care and administration in workmen's compensation cases. The Committee reports progress in the following categories:

### MEDICAL SERVICE

A preliminary report was made in the 1955 Handbook concerning a questionnaire sent to all members of the Society as authorized and directed by the Council. Among items included in the questionnaire were the physician's willingness to render care to injured employees, make examinations to evaluate disability, submit reports, testify, and to accept consultations. 1471 replies were received, of which 1031 accepted, the latter number including 153 whose acceptance was limited because they confined their practice to a certain specialty. It is believed that, both the response and the percentage indicating acceptance, are quite illuminating in expressing the attitude of the profession.

The House of Delegates of the American Medical Association in December, 1955, adopted two re-

ports presented by the Council on Industrial Health, one of them being entitled "Medical Relations in Workmen's Compensation." This included the following recommendation:

> "That the appropriate official medical organization in each workmen's compensation jurisdiction examine and, where necessary, seek adoption of statutory provisions to the end that all patients subject to workmen's compensation laws have the right to accept physicians' services provided by employers or to select another attending physician from a register of all physicians in the community willing and qualified to perform the essential services."

The following statement was also issued:

> "It is hoped that state medical societies will give special attention to developing medical programs in accordance with these recommendations in the immediate future. The majority of state legislatures convene in the early part of 1957. Prompt action will permit medical organizations to be prepared well in advance to implement these programs with appropriate legislation when necessary."

In view of this, the Committee, at its meeting on March 20, approved these recommendations in principle; it was realized, however, that their implementation in Illinois would require either a new Workmen's Compensation Law or an amendment to the existing Law. Such legislation is now being studied.

The Committee has received a number of complaints against physicians in connection with the care of injured employees, both as regards medical reports, the nature of the care rendered, and medical testimony. Two physicians have appeared before the Committee in executive session. The complaints against one doctor were referred to the Ethical Relations Committee of the Chicago Medical Society and as a result of their recommendation, this doctor was suspended from membership in that society for six months. The complaints against the other physician who appeared before the Committee are being given further study. The other complaints have been disposed of either by correspondence or by reference.

Still pending are some complaints involving physicians in connection with the care, reporting and testimony pertaining to railroad injuries.

A very small minority of physicians are involved in these complaints but this small minority does discredit to the entire profession. There is evidence that the Committee's efforts to correct this situation are bearing fruit.

### Liaison with Other Organizations

The Illinois Manufacturing Association has shown active cooperation with the work of this Committee and has made reference to it in three of their bulletins, the last one being October 21, 1955. The Committee held a joint session with a subcommittee of the Illinois Bar Association on October 18. An informal meeting was held with the Chairman of the Illinois Industrial Commission. The Chairman of our Committee attended a meeting with the Board of Governors of the Chicago Society of Industrial Medicine and Surgery.

### Medical Reports and Publications

One of the Committee members has prepared an article entitled "The Essentials of Medical Reports for Employees' Care," which will appear soon in the Illinois Medical Journal. Haphazard certification of illnesses by some physicians has led to some unfortunate experiences and the Committee is cognizant of the need for physicians to use care and discretion in certifying the nature and extent of disability due to illness whether of occupational or nonoccupational origin.

The Committee is studying a suggested Guide for a Workmen's Compensation Handbook for Physicians, which has been developed under the joint auspices of the Council on Industrial Health and the Medical Committee of the International Association of Industrial Accident Boards and Commissions. Material has been presented both to the Illinois Medical Journal and Bulletins of county societies from time to time.

### Legislation

The Committee is studying appropriate legislation to implement recent recommendations made by the House of Delegates of the American Medical Association.

Dr. Stone and the Chairman attended the 16th Annual Congress on Industrial Health in Detroit in January, both being listed on the program as participants. The Chairman had an interview with Governor Stratton on matters pertaining to industrial health problems.

The Committee wishes to express its sincere appreciation to the House of Delegates, the Council, Dr. Harold M. Camp and the staff of the Illinois State Medical Society for their unfailing and valuable support and assistance in the past year.

Respectfully submitted,

Frederick W. Slobe, M. D.,
*Chairman*
Milton H. Kronenberg, M. D.
*Co-Chairman*
Richard J. Bennett, Jr., M. D.
Joseph H. Chivers, M. D.
E. C. Holmblad, M. D.
Samuel L. Keller, M. D.
Clarence F. Kelly, Jr., M. D.
Edward A. Piszczek, M. D.
V. P. Siegel, M. D.
M. J. Tremaine, M. D.
*Committee on Industrial Health.*

DR. FREDERICK W. SLOBE: I have a supplementary report:

To the Members of the House of Delegates:

In the annual report of your Committee on Industrial Health published in the Handbook, reference is made to two reports adopted by the American Medical Association in December, 1955. These reports are entitled (1) "Medical Relations in Workmen's Compensation", and (2) "Physician Selection in Workmen's Compensation", copies of which are attached to this supplementary report.

To conserve space these two reports could not be included in the Handbook, hence they form the basis of this supplementary report. Your Committee recommends that the House of Delegates concur in the recommendations contained therein by the adoption of these two reports, and that the recommendations contained therein be implemented by the appropriate committee or committees and, further, that a progress report with respect to this be submitted to the House of Delegates in May, 1957.

Respectfully submitted,

Frederick W. Slobe, M. D.,
*Chairman.*
Milton H. Kronenberg, M. D.,
Richard J. Bennett, Jr. M. D.
Joseph H. Chivers, M. D.
E. C. Holmblad, M. D.
Samuel L. Keller, M. D.
Clarence F. Kelly, Jr., M. D.
Edward A. Piszczek, M. D.
V. P. Siegel, M. D.
F. Lee Stone, M. D.
M. J. Tremaine, M. D.

THE PRESIDENT: This supplementary report from the Committee on Industrial Health will be referred to Reference Committee "D", Dr. John O. Cletcher, Chairman.

## LIAISON ON MEDICAL EDUCATION

To the Members of the House of Delegates:

There has been no reason for a formal meeting of this committee. Even so, informal discussions

among the members have taken place.

A supplementary report will be presented only in the event that matters pertaining to the purpose of this committee arise subsequently.

Respectfully submitted,

H. Close Hesseltine, M. D.,
*Chairman.*

Jacob E. Reisch, M. D.

Leo P. A. Sweeney, M. D.

*Liaison Committee Medical Education.*

## MATERNAL WELFARE

To the Members of the House of Delegates:

The Maternal Welfare Committee has had as its chief function the study of Maternal Deaths which occurred outside of Chicago. The total number of deaths has been again reduced, reflecting the improved service rendered by the physicians of this area. It is very significant as well as gratifying to note that the mortality rate per 10,000 live births in downstate Illinois is .35 as compared with .37 in the Chicago area. The combined figures place our state well up among the leaders for the United States.

Individually, the members of the committee have been active in supporting other projects for the improvement of Maternal Welfare within the state. Dr. Worling Young has been President of the Illinois Obstetrical and Gynecological Society. Dr. Willard Scrivner has led an active committee of this organization in the study of blood loss in obstetrical cases throughout the downstate area. He has also read papers in that section of the state, using as a basis of discussion, data obtained in our committee studies without quoting specific cases. Dr. Carl Greenstein has taken an active part in organizing the program of the Obstetrical Section of the Illinois State Medical Society's program for 1956. Drs. Allan and Jack Sampson have been active in reviewing the histories of fatal cases and preparing a protocol on each, giv- the facts surrounding the death upon which the committee could make its decision regarding the classification of a given case as preventable or non-preventable and whether or not it should be classified as maternal or non-maternal.

This year "Toxemias of Pregnancy" appears to be the chief cause of death. We plan to make it the main target of the committee and to try to eliminate it. as far as possible, from the causes of maternal mortality.

Committee members have appeared on the program of the Illinois Academy of General Practice discussing subjects of interest to its membership and your chairman presented a scientific exhibit at the Annual Meeting of the Illinois State Medical Society in May, 1955 and at the Postgraduate Clinical Assembly of the Chicago Medical Society held in March, 1956. These activities are difficult to evaluate in a maternal welfare program, but they have a real value in stimulating interest in the work of the Committee and help to reduce maternal morbidity and maternal and fetal mortality and hence reflect credit on our society.

The committee wishes to add that a smooth functioning maternal welfare committee, actively engaged in studying the problems leading to maternal and infant mortality, is in its opinion one of the most powerful factors in promoting good public relations at the disposal of the Illinois State Medical Society.

It is, therefore, desirable for this committee to keep in touch with and to cooperate with all movements within the state leading to greater safety for mothers and babies.

It must also be kept clearly in mind that the general practitioner delivers between 75 and 98 per cent of the babies in this state depending on the locality in which he lives and that the primary function of this committee is to improve his knowledge of this specialty and the conditions under which he must work.

The study of Maternal Deaths is an important though a relatively small part of the work of this committee.

The committee has had five meetings which have been well attended. This year alternates were provided each committee member and these men attended when the regular member was unable to be present.

Respectfully submitted,

Frederick H. Falls, M. D., (District 3) *Chairman.*

*Committee Members:*

Dist. No.

1 - A. B. Owen, M. D.
2 - F. J. P. Twohey, M. D.
4 - W. R. Young, M. D.
5 - Ralph R. Loar, M. D.
6 - Robert K. Hartman, M. D.
7 - J. B. Waller, M. D.
8 - Carl Greenstein, M. D.
9 - Charles E. Ahlm, M. D.
10 - W. C. Scrivner, M. D.
11 - James C. Carey, M. D.

## MEDICAL ECONOMICS

To the Members of the House of Delegates:

Your Medical Economics Committee has just completed another industrious year. commitment of presenting one article, per issue, of the Illinois Medical Journal, has been fulfilled, with the exception of the two issues devoted to the proceedings of the house of delegates.

Medical Economics is a large subject, ever changing in its complexities and facets. Our articles have attempted to call some of these changes to your attention.

The committee feels that more interested downstate physicians should be added to its members, so that the articles will be to a greater extent concerned with the problems of the rural and small town practitioner.

We would like to thank Dr. Harold Camp for his advice and interest and also Miss Ann Fox and those of the Chicago Office for their help in aiding the function of the committee.

Respectfully submitted,

John R. Wolff, M. D.,
*Chairman.*

Walter C. Bornemeier, M. D.
Edward W. Cannady, M. D.
Roland R. Cross, Jr., M. D.
E. F. Deitrich, M. D.
W. W Fullerton, M. D.
Edwin F. Hirsch, M. D.
Frederick T. Jung, M. D.
Caesar Portes, M. D.
William Requarth, M. D.
Frederick W. Slobe, M. D.
*Medical Economics Committee.*

## MEDICAL HISTORY

To the Members of the House of Delegates:

This Committee has been quite inactive since the annual meeting of 1955. Volume II of the Medical History was available for that meeting. Since that time there has been some slight accumulation of material for Volume III. There has been no formal meeting of the Committee since the last annual session.

Respectfully submitted,

James H. Hutton, M. D.,
*Chairman.*

James P. Simonds, M. D.,
Charles P. Blair, M. D.
William A. Mann, M. D.
Archibald Hoyne, M. D.
*ex-officio:*
Tom Kirkwood,
*Permanent Historian.*

## MENTAL HEALTH

To the Members of the House of Delegates:

Your Committee on Mental Health has been somewhat more active this year. This is due in part to the interest of individual members in their communities. They have worked in their county societies and in local agencies. One committee member is President of the County Mental Health Society. Another is extremely active in the local mental health clinic. Two others are active participants in the formation and development of mental health clinics in their respective communities. The members in the metropolitan area spread their wings over many constructive functions. The Chairman, as President of the State Society, has endeavored to correlate mental health features in his appearance at various places over the state.

One very good meeting of the Committee was held at the time of the Conference of Chairmen of State Mental Health Committees at the American Medical Association. Members of the Committee participated in discussions at that Conference.

Liaison with the Illinois Department of Public Welfare has been closer than heretofore. Positive statements have been made regarding various situations that have arisen. Responsibility of physicians over the state regarding their former patients now in state hospitals has continued to be stressed.

There will undoubtedly be various bills in regard to mental health situations introduced into the next session of the General Assembly. It behooves us all to study and watch closely the ideas formulated and the progress of such legislation.

There is much more to be done in this number one problem of our community, state and nation. Continuity of effort and education is essential.

Respectfully submitted,
F. Garm Norbury, M. D.,
Luis V. Amador, M. D.
Walter H. Baer, M. D.
John J. Madden, M. D.
Harry Phillips, M. D.
John L. Reichert, M. D.
Murray E. Rolens, M. D.
*Committee on Mental Health.*

## Report of Editors

To the Members of the House of Delegates:

The Illinois Medical Journal was sent regularly to the nearly 10,000 members of our Society during the past year, as well as to medical libraries and schools throughout the world.

An attempt has been made to include an equitable distribution of editorial and advertising matter, the former consisting of scientific articles, editorials, news, excerpts, and other timely material.

Your editors are pleased to enumerate in this Annual Report several improvements in the contents of the Journal and in other matters concerned with publishing a modern medical journal. We are, as you know, subject to the Council in our efforts and usually endeavor to comply with their recommendations.

We have been fortunate in receiving an adequate number of medical articles of good quality, which compare favorably with articles in other state journals. We are human and have made mistakes in selection but we believe that the majority were of interest to our readers. Highly technical articles have been returned to the authors with the suggestion that they be submitted to one of the specialty journals. We are aware that specialists do write papers that appeal to general practitioners and we are interested in obtaining such articles. They should be submitted to our Monmouth office, where they will be recorded and acknowledged.

Your editors review carefully the articles submitted for publication. When in doubt, we submit them to the Editorial Board for its opinion. We are interested also in short case reports and endeavor to publish two in each issue. We welcome photos and charts to illustrate features of importance.

During the past year we have devoted more time to editing the material. We have had the professional help of a newspaper woman trained in medical as well as journalistic editing and proofreading. Overly long papers have been cut to make them clearer and more concise. This editorial work also includes corrections in spelling and grammar and an attempt to standardize the style in print, heads, spelling, abbreviations, tables, and references.

The proofreading system also has been revised. Now, each of your editors receives a set of galleys from the printers. After proofreading them, the editors go over the changes together, incorporating the authors' corrections. After all corrections are made, one set of corected galleys goes to the printers. This is in contrast to the previous system in which editors, authors, secretaries, and everyone involved sent corrected galleys to the printers, which led only to confusion.

The new feature that appeared this year, "At the Editor's Desk," is designed to acquaint our readers with press and other releases on new ideas, drugs, procedures, and equipment. No recommendations are made; the material is offered as timely data for Illinois physicians.

Excerpts of interest to our readers, taken from leading medical journals, continue to appear in each issue. Occasionally we are criticized on some of these selections or their heads but this shows that these items are read, which means they are worth the time and effort spent in abstracting them. For filler, we use "gems of wisdom" obtained from various sources.

Our new Public Relations Director and Assistant Secretary of the Council, Mr. Edward A. Uzemack, will edit the P. R. page. Our thanks are due to Mr. John A. Mirt for pinch-hitting in this job since the death of Mr. James C. Leary.

"News of the State" items should be sent to the Monmouth office. All county medical societies have something of interest to report on their meetings.

Approximately 75 editorials have appeared this year, on a variety of subjects. Some were scientific; others dealt with current problems along socio-economic lines. Guest editorials from our members are always welcome.

We published 111 original articles during the past fiscal year. This year we will be able to use more because the Council has given us permission to publish the Transactions of the House of Delegates in a supplement that will accompany the July or August issue of the Journal.

Your editors again wish to thank our Business Manager, Mr. L. E. Malley, for fine work he has done to improve our Journal. He also prepares the advertising contacts, which are submitted to the Journal Committee before they are accepted. Mr. Malley makes up the dummy for the book and meets with your editors each Tuesday for a discussion of policies and to compare our Journal with others that come to the Journal office.

We also thank the members of the Journal Committee and the Editorial Board for their continued interest in the finished product—the Illinois Medical Journal. Many problems are considered by this group at the meetings held quarterly.

Mrs. Wanda Ross, of the Monmouth office, deserves thanks for listing and acknowledging the papers submitted to us by authors. This system mimimizes the loss of papers. Occasionally, despite our best efforts, an article is misplaced, which is most embarassing to us.

Thanks also go to Miss Marion Carey, of Chicago, for her editorial work and proofreading.

In closing this report, your editors again want to mention that they appreciate comments from the House

of Delegates and recommendations for changes they believe would improve the Illinois Medical Journal.

Respectfuly submitted,
HAROLD M. CAMP, M. D.
THEODORE R. VANDELLEN, M. D.
*Editors*

## MILITARY AFFAIRS AND EMERGENCY MEDICAL SERVICE—CIVIL DEFENSE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Committee on Military Affairs and Emergency Medical Service has not found it necessary to meet during the past year, but anticipates a renewal of its activity following the completion of the National Survival Study now in progress.

1. The overall picture of Civil Defense in Illinois is one of "watchful waiting" and continued planning. It is believed that little progress can be expected until the completion of the National Survival Study next year.

2. Progress is being made in the National Survival Study project for which Congress has appropriated $10,000,000 during the last session.

3. There has been no further implementation of the First Aid Station and the F. C. D. A. Emergency Hospital program during the past year. Steps are being taken to secure two or more of the Civil Defense Emergency Hospitals (200 bed capacity) on loan from the F. C. D. A. for purposes of demonstration, education and training for the personnel in the health services.

4. The training of radiological monitoring instructors is progressing rapidly in 25 institutions of higher learning throughout Illinois under the guidance of the Department of Public Instruction.

5. The immunization program concerning Civil Defense personnel is being continued, but because of the urgency of the Polio situation, is not being actively publicized.

Respectfully submitted,
EARL H. BLAIR, M. D.
*Chairman*
C. L. CARTER, M. D.
KENNETH H. SCHNEPP, M. D.
R. R. CROSS, M. D.
LEO P. A. SWEENEY, M. D.
PHILIP LEWIN, M. D.
GILBERT EDWARDS, M. D.
*Committee on Military Affairs and Emergency Medical Service.*

## NECROLOGY

A record of deaths of members since the last annual meeting has been compiled by the Secretary's office for the Necrologist. The information is taken from reports of county society secretaries, newspapers, the Journal of the A. M. A. and other sources.

The following list, which indicates the last address and date of death of the members, includes the names of several former officers of the state society and many who have served with distinction in their county medical societies.

Respectfully submitted,
E. H. WELD, M. D.,
*Necrologist.*

Abt, Isaac A., Chicago November 22, 1955; International authority on children's diseases and one of Chicago's most distinguished physicians. Recipient of Distinguished Service Medal of the A. M. A., 1948. Professor of Pediatrics and chairman of department, Northwestern University Medical School. Served as president of American Pediatric Society, American Academy of Pediatrics, Chicago Medical Society, Institute of Medicine of Chicago, Chicago Pediatric Society and the American Association of Teachers of Diseases of Children. Chevalier of the Legion of Honor of France, Member of the House of Delegates, A. M. A. and chairman of the Section of Diseases of Children.

Albus, William R., Chicago, September 10, 1955. Formerly a member of the professional field staff of the Council on Medical Education and Hospitals of the A. M. A.

Allen, Harvey S., Chicago, May 30, 1955, prominent Chicago surgeon, specialized in treatment of burns and hand injuries. Attending surgeon at Passavant and County hospitals and professor of surgery at Northwestern University Medical School.

Allison, Hugh, Grayville, December 26, 1955.

Backer, Meyer, Chicago, May 13, 1955.

Ball, Elizabeth B., Springfield, December 31, 1955. Associated with the Department of Public Health for 25 years.

Barickman, Robert I., Streator, March 9, 1956. Past president of the LaSalle County Medical Society.

Barothy, Arpad M., Chicago, April 29, 1955.

Berry, Frederick, Chicago, October 11, 1955.

Birmingham, E. E., Chicago, July 3, 1955.

Birnbaum, Richard, Noble, March 29, 1955. Served as Secretary of the Richland County Medical Society, 1949-1952.

Blankmeyer, Harrison C., Springfield, December 31, 1955.

Blaufuss, Armin L., Geneva, October 4, 1955.

Blim, Spencer P., Chicago Heights, January 25, 1956.

Bovik, Leslie E., Lake Forest, March 5, 1956. Past president of Lake County Medical Society.

Bowles, Marion K., December 30, 1955. Past president of the Will-Grundy County Medical Society, and Illinois Business and Professional Women's Club.

Bowser, Harold C., Urbana, August 29, 1955.

Branom, LeRoy, Lincoln, September 11, 1955. Past president of the Logan County Medical Society and the Logan County Tuberculosis Association.

Brewer, Lewis R., Oak Park, February 26, 1956.

Bryant, J. Edmond, Evanston, December 18, 1955.

Buck, Margaret M., Chicago, November 3, 1955.

Burdick, G. G., Chicago, December 13, 1955.

Burkhart, Victor H., Hurst, July 27, 1955.

Cargill, Chauncey, Mason City, February 20, 1955. Past president of the Mason County Medical Society.

Casto, Parley C., St. Joseph, May 13, 1955.

Chesrow, Albert J., Chicago, June 12, 1955.

Clayton, John W., Johnston City, November 10, 1955.

Cole, Alvin V., Bronxville, New York, February 18, 1955.

Cook, Carroll Eugene, Oak Park, December 24, 1955.

Corbett, Mitchell S., Oak Park, February 29, 1956. Staff physician of the Illinois Athletic Commission since 1930. Pioneer in industrial surgery.

Corwin, Charles T., Chicago, December 24, 1955.

Cottrell, Thomas, Chicago, May 3, 1955.

Curtis, Arthur H., Lutsen, Minnesota, November 13, 1955. Professor and chairman of the department of obstetrics and gynecology for many years at Northwestern University Medical School. Member of the House of Delegates of the A. M. A., 1932-1934. Past Secretary and President of American Gynecological Society. Past President of the Chicago Gynecological Society.

Danielson, Wilford A., Chicago, June 29, 1955.

Davidson, Herman P., Chicago, October 9, 1955.

Davis, Nathan Smith III, Winnetka, April 20, 1956. Grandson of the founder of the A. M. A. Past president of the Chicago Academy of Sciences, Past president and secretary of the Chicago Medical Society, Past president and secretary of the Academy of Internal Medicine. Served as First Vice-President of the Illinois State Medical Society and Chairman and Director, Committee on Scientific Exhibits.

Deardorff, Frank B., Berwyn, July 12, 1955.

Deuterman, LeRoy, Elgin, August 7, 1955.

Dickinson, Harry B., Coulterville, June 11, 1955.

Dicus, George, Streator, June 9, 1955. Recipient of Outstanding General Practitioner Award, Illinois State Medical Society. Past President of LaSalle County Medical Society.

Doerann, August F., Evanston, June 13, 1955.

Duff, Roden R., Chicago, February 11, 1955.

Dunston, Edwin L., Chicago, April 15, 1955.

Dwyer, Daniel R., Ottawa, April 4, 1956.

Edwards, Francis M., Cisco, October 17, 1955.

Edwards, Robert W., LaGrange, August 10, 1955.

Ellis, James J., West Frankfort, January 24, 1956. Past President of the Franklin County Medical Society.

Ellis, John D., Denver, Colorado, died March 9, 1956.

Elworthy, Robert W., Elmhurst, March 14, 1956. Past President of the DuPage County Medical Society.

Felts, Harvey A., Marion, January 7, 1956. Past Secretary of the Williamson County Medical Society. Delegate to the House of Delegates, Served as Vice-President of the Illinois State Medical Society.

Ferguson, Oscar W., Mattoon, November 26, 1955.

File, Richard C., Decatur, August 30, 1955.

First, Frank H., Rock Island, January 7, 1956.

Fitz, Frederick W., Chicago, October 8, 1955. Associate professor of medicine at Northwestern university and chief of the university's heart and circulation clinic, Medical counsellor of the Tribune, 1939-1941.

Fox, William W., Lincoln, November 16, 1955. Past President of the Logan County Medical Society. Superintendent of Lincoln State school since 1938. Past vice-president of the American Association on Mental Deficiency.

Framing, Edward C., Galesburg, March 17, 1956.

Frankenstein, Victor S., Chicago, June 15, 1955.

Franks, Arthur Jr., Harrisburg, May 3, 1955. Past president of the Saline County Medical Society.

Gaebler, Arthur, Chicago, May 15, 1955.
Gindich, Morris H., Lake Villa, February 26, 1956.
Glatter, Zoltan, East Moline, June 17, 1955.
Goldfine, Manuel, Chicago, May 7, 1955.
Graber, Ben P., Barrington, November 30, 1955.
Greider, Frank C., Decatur, December 19, 1955.
Hall, Philip V., Moline, June 16, 1955.
Hambrecht, Fred, Galesburg, June 1, 1955.
Hastings, James B., Alton, May 21, 1955. Past President of the Madison County Medical Society.
Hayes, Robert H., Chicago, December 10, 1955. Delegate to A. M. A. and Illinois State Medical Society House of Delegates. Served for many years as chairman of Committee on Medical Benevolence and Committee on Tuberculosis Control.
Haynes, Halbert A., Chicago, July 5, 1955.
Hennan, Clarence W., Chicago, February 28, 1956. Past president of the Chicago Society of Industrial Medicine and Surgery.
Henry, James C., East St. Louis, May 24, 1955.
Herrmann, Nicholas A., Harrisburg, February 28, 1956. President of Saline County Medical Society at the time of his death.
Hess, Julius H., Chicago, November 2, 1955. Internationally known pediatrician who was noted for his pioneering efforts in saving the lives of premature infants. Professor and head of the department of pediatrics at the University of Illinois for 30 years. Past President of the Chicago Medical Society. Recipient of Borden award of the American Academy of Pediatrics.
Hewitt, William P., Chicago, March 21, 1955.
Hill, G. Ray, Rochelle, June 11, 1955. Past president and past secretary of the Wayne County Medical Society.
Hines, Lawrence E., Chicago, May 13, 1955. Professor of medicine at Northwestern University medical school.
Jack, John B., Auburn, Nebraska, November 5, 1955.
James, Peter F., Peoria, August 26, 1955.
Johnson, George F., Montalvo, California, August 6, 1955.
Kampen, Harry L., Monmouth, April 16, 1956. Past president of the Warren County Medical Society.
Kelly, Blair, Ferris, August 25, 1955. Past president and secretary of the Hancock County Medical Society.
Kelly, Raymond M., Chicago, July 15, 1955.
King, Walter W., Peoria, April 13, 1955.
Kinne, Harry W., Sarasota, Florida, November 3, 1955.
Klaptoz, Adelberg, Chicago, August 8, 1955.
Klucikowski, Norbert A., Evergreen Park, December 16, 1955.
Koehler, Gottfried, Bonita Springs, Florida, December 18, 1955.
Kramer, Gabriel B., Rockford, April 6, 1955.
Kuehn, Albert A., Bluffs, July 31, 1955.
Landau, George M., Lincolnwood, died April 10, 1956. Director of the X-ray and therapy department at Cook County hospital since 1942. Past president of the Chicago Roentgen Society and an assistant professor of radiology at Northwestern University. Served as Section Officer of the Illinois State Medical Society.
Leininger, Elmer C., Chicago, July 11, 1955.
Lenz, Joseph A., Chicago, May 22, 1955.
Lester, Harry S., Streator, June 24, 1955.
Levinson, Abraham, Chicago, September 17, 1955. Chief of staff of Cook county children's hospital. Professor of pediatrics at Northwestern.
Lewis, Marvin A., Leonia, New Jersey, June 21, 1954.
Lollar, Myron E., Tuscola, April 4, 1956. Past president of the Douglas County Medical Society. Only physician-member of House of Representatives, State of Illinois; 34th District.
Lutton, Ethelbert A., Chicago, October 1, 1955.
McCorvie, John E., Peoria, October 29, 1955.
McCradie, Andrew R., Chicago, September 8, 1955.
McNeil, Gordon C., Oak Park, February 3, 1956.
McPherson, Warren G., Bement, November 15, 1955.
MacEachern, M. T., Chicago, February 3, 1956. Past president of the American Hospital Association, the Chicago Medical Society and the American Protestant Hospital Association.
Makar, Ignatius Edward, Chicago, April 17, 1955.
Mantell, Bernard, Maywood, February 18, 1955.
Marxer, Barney, DuPo, November 16, 1955. Past president of the St. Clair County Medical Society.
Meacham, Hubert F., Chicago, July 29, 1955.
Mendelsohn, Jacob J., Chicago, July 26, 1955.
Mershon, Glenn E., Mt. Carroll, October 11, 1955. Past president of the Carroll County Medical Society.
Merwin, Edgar G., Highland, September 30, 1955.
Meyer, Jacob, Chicago, December 17, 1955. Professor of medicine, University of Illinois. Ex-president of Michael Reese Hospital staff.
Miller, George Henry, Bellaire, Michigan, November 13, 1955.
Milton, Benjamin S., Chicago, December 22, 1955.
Mitchell, William J., Chicago, July 28, 1955.
Monash, David F., Chicago, November 5, 1955.
Mroz, Rudolph J., Rockford, March 16, 1956. Past president of the Winnebago County Medical Society.
Murrah, Frank C., Herrin, October 21, 1955. Past president of the Williamson County Medical Society.
Nassar, Naif E., Chicago, August 24, 1955.
Noe, Philip, Centralia, July 16, 1955.
Norris, Clarence O., Arthur, March 12, 1956. Past president of the Douglas County Medical Society.
Nuzum, John W. Jr., Houma, La., August 15, 1955.
Ochsner, Edward H., Chicago, January 22, 1956. Past president of Illinois State Medical Society (1924) and Illinois state charities commission. Member of House of Delegates of I. S. M. S. and Fifty Year Club Committee.
Opitz, John H., Chicago, October 16, 1955.
Parkes, Charles H., Sharon, Wisconsin, January 10, 1955.
Peairs, Ralph P., Normal, December 19, 1955. Served as Councilor, 5th District, Illinois State Medical Society for many years. Long time secretary of McLean County Medical Society.
Perusse, George L, Sr., Chicago, July 15, 1955. Former superintendent of Michael Reese Hospital.
Peters, John, Oak Park, January 29, 1956. Chief of staff at Oak Park Hospital and past president of Chicago Society of Allergists.
Peterson, Carl M., Chicago, September 27, 1955. Secretary of Council on Industrial Health, A. M. A. since 1938. Former staff associate of Council on Medical Education and Hospitals of A. M. A.
Poncher, Henry G., Valpariso, Indiana, May 31, 1955. Former chief of pediatrics at University of Illinois school of medicine, where he was on the faculty for 24 years. Director of health at Valpariso University at the time of his death.
Ponne, Jerome F., Chicago, May 20, 1955.
Prescott, Harry V., Dallas City, August 8, 1955. Past president of the Hancock County Medical Society.
Ragins, Oscar B., Chicago, November 18, 1955. Head physician of the Municipal Tuberculosis Sanitarium Clinic at Provident Hospital. Clinical associate professor of medicine at the University of Illinois.
Raleigh, Gordon W., Evanston, April 13, 1955. Former Director of the graduate division of Northwestern University Medical School.
Rendtorff, Walter, Allegan, Michigan, died March 15, 1956.
Rieger, Karl B., Freeport, March 20, 1956. Past president and secretary of the Stephenson County Medical Society. Served as a member of the House of Delegates, Illinois State Medical Society.
Roberts, John C., Peoria, June 19, 1955.
Rosenberg, Harry, Los Angeles, California, September 18, 1955.
Rosenblate, Adolph J., Chicago, October 12, 1955.
Roth, Henry H., Murphysboro, May 19, 1955. Past president of the Jackson County Medical Society.
Ruud, Helga, Chicago, January 29, 1956. Died at the age of 95, after specializing in obstetrics and gynecology in Chicago for 54 years. Former teacher at Northwestern University.
Ryan, David C., Peoria, February 3, 1956.
Samuel, Jacob, Chicago, September 19, 1955.
Schiltz, Frank A., Decatur, November 12, 1955.
Schowengerdt, William E., Champaign, March 2, 1956. Past president of the Champaign County Medical Society.
Senturia, Ben D., Chicago, July 18, 1955.
Sheerer, Walter W., Christopher, May 2, 1955.
Shurtz, Richard C., Champaign, July 29, 1955.
Sims, Leslie B., Farmington, February 2, 1956.
Souders, John C., Rock Island, August 23, 1955. Past president of the Rock Island County Medical Society.
Speed, Kellogg, Laguna Beach, California, July 2, 1955. Founder of American Board of Surgery and American Board of Orthopedic Surgery. Former professor of surgery at University of Illinois. Former head surgeon at Presbyterian Hospital. Chairman, Special Committee on Fractures, A. M. A., 1928-1947. Member of Illinois Medical Journal Editorial Board and Committee on History, I. S. M. S.
Stacy, George H., Peoria, January 22, 1956.
Stephens, V. R., Interlochen, Michigan, December 2, 1955. Former professor in surgery, University of Illinois.
Stern, Jacob, Chicago, December 20, 1955.
Stevenson, Frank H., Chicago, April 16, 1955.
Streicher, Michael H., Chicago, February 9, 1956. Associate professor of medicine at the University of Illinois Medical College.
Stubenrauch, Charles Henry Sr., Quincy, June 21, 1955. Past president and secretary of the Mason County Medical Society.
Sullivan, John T., Chicago, April 15, 1956.
Theobald, John J., Oak Park, July 5, 1955. Assistant professor of rhinology and otolaryngology at the University of Illinois Research Hospital.
Thompson, Frank P., Chicago, May 26, 1955.
Trace, Isadore M., Chicago, May 4, 1955. Professor of medicine at Chicago Medical School.
Vanatta, Clyde L., North Madison, Indiana, May 15, 1955.
Waldman, Joseph S., Belleville, March 29, 1955.
Weber, Bernard A., Olney, January 27, 1956. Past president of the Richland County Medical Society.
Weiss, Emil, Chicago, June 2, 1955. Former member of faculties of Loyola, University of Illinois and Northwestern.
Welch, Gilford N., Centralia, June 28, 1955.
Weiner, Samuel H., Chicago, May 7, 1955.
Williams, Mary E., Chicago, January 17, 1956.
Winn, John P., Murphysboro, May 21, 1955.
Wolfer, John A., Banning, California, November 21, 1955. Professor emeritus of surgery and director of the tumor clinic at the Northwestern University Medical School. Recipient of honor medallion of the Illinois division of the American Cancer Society in 1950 for outstanding work in cancer control. Member of Committee on Cancer Control, I. S. M. S.

## NUTRITION

To the Members of the House of Delegates:

On Sunday evening, June 26th, the Committee on Nutrition held a meeting at the Conrad Hilton Hotel. The subject of the meeting was Mass Feeding in its relationship to feeding people who are incarcerated, and feeding of people who are unable to obtain food in abundance. Dr. F. Garm Norbury, President of the Illinois State Medical Society, spoke on Feeding of Patients in a Small Institution. Dr. Norbury spoke of the need for an adequate well balanced diet in its relationship to convalescence, and also on the economics of supplying such a diet. Lt. Col. Ryer of the United States Army gave a learned discussion from first hand knowledge of feeding the German populace immediately after the war, and the amount of calories required per day to produce health and well being. Lt. Col. Ryer was arranged for through the Surgeon General of the Army. At this meeting representatives were present from the Medical Profession, and the Chicago Nutrition Association. Governor Stratton had a personal representative there as did the Dean of the University of Illinois College of Medicine. Representatives of the State Department of Public Welfare were also in attendance. The Committee on Nutrition is desirous to further the cause of our program on Mass Feeding.

On Monday, June 27, 1955, the Committee on Nutrition of the Illinois State Medical Society for the year 1955-1956 co-sponsored the Fourteenth Annual Institute on Conservation, Nutrition and Health of the Friends of the Land. This meeting was held at the Illini Union Building of the University of Illinois College of Medicine, and the Conrad Hilton Hotel. Through the cooperation of the Postgraduate Education Committee of the Illinois State Medical Society, the Committee on Nutrition arranged for the first day of the three day Institute. The theme was, Feeding the Sick, and we were very fortunate in having the services of Drs. Kark, Everson, Paul and Kaplan, who were procured through the Postgraduate Education Committee. Also, Drs. Wright Adams and John Dale Owen spoke. The message that Dr. John Dale Owen brought before the group; i .e., The Poor Nutritional Status of the Expectant Mother, was very well received and was of such noteworthy interest to have received a national press.

The second day encompassed such subjects as diets in relation to climate, in relation to age—also the present knowledge of tooth decay. The evening session was devoted to a study of Soil, Food and People by Dr. Firman Bear of Rutgers University, and a comprehensive review on the Nutrition Program for the Latter Half of Life, by Dr. Clive McCay, who is Professor of Nutrition, Cornell University, Ithaca, New York. The third day had as its theme, Let's Improve the Quality of our Food, and was devoted for the most part to Conservation. Dr. Theodore VanDellen gave a most instructive talk on, Motivating the Public to Give Concern about Its Nutritional Status. He dwelt at some lengths upon the proper approach to the public through the various media of press, radio and TV, with special emphasis on the methods of obtaining a good press by an organization.

We on the Committee are happy to be associated with this movement for proper nutrition. We appreciated the attendance of the University of Illinois College of Medicine, and the address of welcome by Dr. Granville Bennett, Dean, College of Medicine, University of Illinois. Dr. Jonathan Forman of Columbus, Ohio, President of the Friends of the Land, is and has always been a hard worker in the realm of good nutrition. The Commission on Education of the Illinois Academy of General Practice is also thanked for their kindness in permitting informal postgraduate credit to those members who attended these meetings.

At a meeting of the Committee on Nutrition held September 3, 1955, Drs. Newcomb, Otrich, Wilson and the Chairman were present, along with Mr. John Mirt of the Illinois State Medical Society, and Mr. Ollie Fink, Executive Secretary of the Friends of the Land. The Committee on Nutrition was invited to again participate in the Annual Institute of the Friends of the Land which will be held in June, 1956. This will be the Fifteenth Annual Institute. The Committee voted unanimously to request permission of the Council of the Illinois State Medical Society to grant us this permission.

Also the Committee on Nutrition has been invited by the President of the Chicago Nutrition Association to cooperate with the Chicago Nutrition Association in the presentation of a program in Chicago, on the subject of Nutrition in Women before and during the Child-bearing Age. I would like at this time to read a letter which I have received from Dr. James R. Wilson, a member of the Committee on Nutrition, who is also President of the Chicago Nutrition Association.

"As President of the Chicago Nutrition Association, I have proposed that the Nutrition Committee of the Illinois State Medical Society be requested to cooperate with the Chicago Nutrition Association in the presentation of a program in Chicago on the subject of Nutrition of Women During the Child-bearing Age. It would be possible to hold this meeting in the late winter I believe, perhaps March.

"It is my belief that my board will not only approve but greet this proposal with interest and enthusiasm. In order to facilitate matters, may I request that you explore the possibility of securing support and permission to engage in this cooperative enterprise.

"In my opinion there could be large interest in this program."

Sincerely,
James R. Wilson, /s

Permission was granted by the Council of the Illinois State Medical Society for the Committee on Nutrition to again co-sponsor with the Friends of the Land, the Fifteenth Annual Institute on Soil, Food and Health Relationships to be held on the 25th 26th and 27th of June.

The Council also approved participation in a joint endeavor of the Committee on Nutrition and the Chicago Nutrition Association for a meeting to be held in April, the general theme of which is to be "The Right of a Baby to be Born of a Healthy Mother." For this meeting, to be held April 26, 1956, the following have consented to participate. Dr. Lee Stone, President-Elect of the Illinois State Medical Society to give the address of welcome. Fr. Joseph Mangan, S. J., Professor of Moral Theology, St. Mary of the Lake Seminary, Mundelein, Illinois, who will discuss the moral and ethical considerations involved. Dr. H. Close Hesseltine, Professor, the Department of Obstetrics and Gynecology, University of Chicago, who will speak on the Importance of Nutrition in Women from an Obstetrical Standpoint. In addition, Dr. Grant Laing of Chicago has accepted an invitation to speak on the Nutritional Aspects.

The work of the Committee in conjunction with the Friends of the Land will consist of a National Nutritional Conference on the first day of the Fifthteenth Annual Institute on Soil, Food and Health Relationships to be held at the Conrad Hilton Hotel, Chicago, Illinois on June 25h, 26th, and 27th. The list of the speakers and the subjects so far arranged are as follows for the morning and afternoon sessions.

Dr. Edward F. Neckermann—"Proteins in a Balanced Diet"

Dr. E. T. McEnery—"Food Supplements in Nutrition"
Dr. Wm. Raycraft—"Infant Feeding for Health"
Dr. Joseph Christian—"Diets for the Sick Baby"
Dr. Melvin M. Shertack—"The Diet After 50"

The evening meeting promises to be very interesting and will be a session devoted to Education and Nutrition. Drs. Wilson and Miller, members of this Committee, have kindly consented to arrange for these speakers. Dr. Zoe Anderson of the Daily Institute is meeting today with Drs. Wilson and Miller to make definite plans for this meeting.

Through the Scientific Work Committee of the Illinois State Medical Society, Dr. James Reyniers, Director of Lobund Institute and Professor of Bacteriology, The University of Notre Dame, was invited to speak to the General Assembly of the Annual Meeting of the Illinois State Medical Society, Thursday afternoon, May 17, 1956. Dr. Reyniers will speak on the subject of "Diets of Germ-Free Animals from the Suckling Age Through Maturity." The work that Dr. Reyniers and his staff at the University of Notre Dame are doing is becoming of international importance. We on the Committee feel that this talk will be one of the highlights of the 1956 General Assembly of the Illinois State Medical Society.

A supplementary report will be made verbally to the House of Delegates which will include the programs of the combined meeting with the Chicago Nutrition Association and the Fifteenth Annual Institute of the Friends of the Land.

Respectfully submitted,

PAUL A. DAILEY, M. D.
*Chairman*
HARRY MANTZ, M. D.
G. C. OTRICH, M. D.
WARNER H. NEWCOMB, M. D.
JOHN P. O'NEIL M. D.
JOHN J. MILLER, M. D.
JAMES R. WILSON, M. D.
*Committee on Nutrition.*

## NURSING

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Your committee has had a very active year with many meetings which were well attended. In spite of all efforts the number of schools of nursing is decreasing, and the total number of students enrolled is also declining.

We wish to briefly review the population trends in Illinois because this will reflect the future need for nurses.

Illinois is the fourth largest state in the United States in population and has shown remarkable growth.

1850 851,470 population in Illinois
1950 8,712,176 population in Illinois
1955 9,239,000 population in Illinois

The aged are increasing:
1900 4% of population over 65 years of age
1950 8% of population over 65 years of age

Size of families:
3.45 people to a family

Live Births:
1953 202,689 in Illinois
1954 213,055 in Illinois (Increase of 5.1%)

Birth Rate (Illinois):
22.5 (per 1,000 population) 1953
23.2 (per 1,000 population) 1954 Increase 3.1%

Deaths in Illinois (all ages):
Number 95,216 in 1953
91,044 in 1954 (Decreased 4.4%)
Rate 10.6 in 1953
9.9 in 1954 (Decreased 6.6%)

Infant Deaths under 1 year:
Number 5,152 1953
5,096 1954 (Decreased 1.1%)
Rate 25.4% 1953
23.9% 1954 (Decreased 5.9)

We wish to point out in summary that in Illinois, the birth rate is increasing, the death rate is decreasing, the number of people over 65 years of age has doubled, and that the average lifetime has increased to about 70 years of age. We also wish to remind you that there was a baby boom in 1940.

The number of high school graduates (U. S.) is as follows: (These are the people eligible to enter a school of Nursing)

| | *Men* | *Women* | *Total* |
|---|---|---|---|
| 1900 | 38,075 | 56,808 | 94,983 |
| 1950 | 570,700 | 629,000 | 1,193,000 |
| 1954 | 640,200 | 716,200 | 1,356,400 |

The following tables prepared after a very recent survey by Illinois Hospital Association show the trends in nursing education in Illinois.

| *Year.* | *Total schools* | *Total Enrollment* | *Unfilled openings.* |
|---|---|---|---|
| 1950-1951 | 81 | 7,229 | 1,800 |
| 1951-1952 | 80 | 7,020 | 1,916 |
| 1952-1953 | 79 | 6,887 | 1,474 |
| 1954-1955 | 72 | 6,663 | 810 |
| 1955-1956 | 70 | 6,663 | 1,348 |

Schools of Nursing closed since 1950.
Their total class and enrollment.

| *City* | *School* | *Date clsd.* | *Max. class* | *Max. Enrl.* |
|---|---|---|---|---|
| Chicago | Englewood Hosp. | 1953 | 25 | 75 |
| | Garfield Pk Com. | 1950 | 30 | 60 |
| | Henrotin June | 1956 | 25 | 60 |
| | Mother Cabrini | 1951 | 20 | 45 |
| E. St. Louis | Christian Welfare | 1955 | 35 | 60 |
| Elgin | Sherman | 1952 | 30 | 50 |
| Freeport | St. Francis | 1955 | 25 | 50 |
| Granite City | St. Elizabeth | 1955 | 20 | 50 |
| LaSalle | St. Mary's | 1953 | 20 | 50 |
| Macomb | St. Francis | 1954 | 25 | 45 |
| Ottawa | Ryburn Mem. | 1955 | 20 | 60 |
| Paris | Paris Hosp. | 1954 | 15 | 50 |
| Peoria | John C. Proctor (Closing) | 1956 | 25 | 60 |
| | | | 340 | 775 |

ILLINOIS HOSPITAL SCHOOLS OF NURSING ENROLLMENT 1955-1956

Cook County—Number of schools ..... 34
Max. Possible enrollment with present faculty 4,685
Max Possible enrollments with all faculty openings filled .....4,870
Present Total Enrollment .....3,842
Unfilled ..... 843
Potential for more students at full faculty....1,028
Fall class potential .....1,841
Fall class actual .....1,588

Other Counties—Number of Schools ..... 36
Max. Possible enrollment with present faculty 3,326
Max. Possible enrollment with all faculty openings filled .....3,539
Present total enrollment .....2,821
Unfilled ..... 505
Potential for more students at full faculty .... 718
Fall class potential .....1,410
Fall class actual .....1,232

Totals—No. of Schools ..... 70
Max. Possible enrollment with present faculty 8,011
Max. Possible enrollment with all faculty openings filled .....8,409
Present total enrollment .....6,663
Unfilled .....1,348
Potential for more students at full faculty ....1,746
Fall class potential .....3,251
Fall class actual .....2,820

Cook County—No. of schools with maximum enrollment at present faculty ..... 6

No. of schools without maximum enrollment at present faculty .....28
No. of schools could take more students if they had more faculty ..... 5
No. of schools not needing more faculty .....29
Other Counties—No. of schools with maximum enrollment at present faculty ..... 7
No. of schools without maximum enrollment at present faculty .....29
No. of schools could take more students if they had more faculty .....14
Number of Schools not needing more faculty ....22

Totals—No. of schools with maximum enrollment at present faculty .....13
No. of schools without maximum enrollment at present faculty .....57
No. of schools could take more students of they had more faculty .....19
No. of schools not needing more faculty .....51

SUMMARY:

Since 1950, 14 schools of nursing in Illinois have closed. They had a capacity for 340 students in fall classes and a maximum enrollment of 775 students.

A map showing the geographical distribution of schools of nursing in Illinois will be available for the House of Delegates.

COLLEGIATE PROGRAMS IN NURSING IN ILLINOIS

At present the following programs are offered in Illinois:

De Paul University—B. S. in Nursing.
Loyola University—B. S. in Nursing; B. S. in Public Health Nursing.
University of Illinois—B. S. in Nursing.

APPROVAL AND ACCREDITATION

All 70 schools of nursing in Illinois are approved by the Department of Registration and Education of the State of Illinois.

National accreditation is voluntary and is by the accrediting service of the National League for Nursing. There are two types, Full Accreditation and Temporary Accreditation.

Temporary accreditation is due to end Dec. 31, 1957, and it has been announced that a new type of accreditation called Provisionally Accredited will be available to schools which have demonstrated to the Boards of Review the probability that they can be fully accredited by Dec. 31, 1959, will be provisionally accredited and this type will end on Dec. 31, 1959. It has been estimated that probably only 60 per cent of the temporary accredited schools at the present time will be able to obtain full accreditation, within the time limit.

There are 70 hospital schools of nursing in Illinois at the present time.

Cook County—Full Accredited .....14
Temporary Accredited .....16
Schools without national accred. ..... 4
Total No. of Schools .....34
Other Counties—Full Accredited ..... 3
Temporary Accredited .....26
Schools without national accred. ..... 7
Total No. of Schools .....36

Totals—Full Accredited .....17
Temporary Accredited .....42
Schools without national accred. .....11
Total No. of schools .....70

The fully accredited schools are:

Cook County—
Chicago—Augustana, Chicago Wesley Memorial, Cook County, Grant, Michael Reese, Mt. Sinai, Presbyterian, St. Anne's, St. Elizabeth's Mercy, St. Joseph's, St. Luke's.
Evanston—Evanston H., and St. Francis H.
Other Counties—
Decatur:
Decatur and Macon County Hospital.
Peoria,:
Methodist Hospital, St. Francis Hospital.

MENTAL HEALTH NURSING

In an effort to obtain nurses the Department of Public Welfare has launched an Employment-Education Program for Student Nurses. The state offers to provide payment for: tuition, fees, books, uniforms, and a monthly stipend of $30.00 first year, $40.00 second year, and $50.00 third year, for up to three years in either a hospital or collegiate nursing program in Illinois Schools to Illinois residents. In return they agree to work for one year for each year of training.

PRACTICAL NURSES

Your committee and the officers and committees of the various local county medical societies have worked together with the Board of Vocational Education of the State of Illinois, to help to establish Practical Nurse Schools in areas that desire schools.

Respectfully submitted,
MAURICE M. HOELTGEN, M. D.
*Chairman*
HOMER JUNKIN, M. D.
F. M. NICHOLSON, M. D.
JOHN LESTER REICHERT, M. D.
PAUL P. YOUNGBERG, M. D.
J O. FIRTH, M. D.
PATRICK H. MCNULTY, M. D.
WILLIAM H. SCHOWENGERDT, M. D.
*Committee on Nursing.*

DR. MAURICE M. HOELTGEN, Chicago: I have a supplementary report from the Committee on Nursing.

MR. CHAIRMAN AND MEMBERS OF THE HOUSE OF DELEGATES:

The Committee on Nursing has prepared a map of the schools of nursing in the State of Illinois but unfortunately we do not have enough copies for every member of the House. This map shows the location of fully graded schools at national level, temporarily graded schools and state and private schools. We will also have statistics on the schools which have been closed. Secondly, we have for every member of the House this booklet on professional schools of nursing. You should receive a copy today or tomorrw. There is also a booklet listing the practical schools of nursing. There is one for every member of this House of Delegates.

I would like to draw your attention to the Springfield News Letter—there are copies on the table at the entrance—which has considerable information regarding the nursing situation. The Nursing Committee was given a resolution which has been prepared and we were directed by the Council of the Illinois State Medical Society to present this resolution to you. The resolution is as follows:

WHEREAS, at the 1955 Annual Meeting of the Illinois State Medical Society the House of Delegates passed a resolution requesting the Governor of the State of Illinois to appoint a commission composed of practicing physicians, nurses, hospital administrators and educators to study the problems of the nurses' training schools in Illinois; and

WHEREAS, the Council of the Illinois State Medical Society after careful consideration passed the following resolution:

"That the Council of the Illinois State Medical Society request the Governor to appoint a separate commission composed of practicing physicians, nurses, hospital administrators and educators to conduct a study of the critical shortage of nurses' training schools and teaching facilities for nurses within the state", and

WHEREAS, a copy of this Resolution was sent to the Honorable William G. Stratton, Governor of Illinois, under date of August 15, 1955, and another letter of similar character on March 13, 1956, and

WHEREAS, the American Legion, Department of Illinois, has passed a similar resolution, and has made similar requests on two occasions to the Governor; and

WHEREAS, the Illinois Agricultural Association has become interested and concerned over this critical situation created by the closing of a large number of nurses' training schools in Illinois in a relatively short time,

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Illinois State Medical Society at this 1956 Annual Session will ask that the Society support legislation which would create a Governor's Commission of perhaps twelve members to be appointed by the Governor, composed of two practicing physicians, two nurses, two hospital administrators, two educators, two members of the American Legion of Illinois, and two members of the Illinois Agricultural Association, to study the critical shortage of nurses' training schools in Illinois, and recommend a program which will discourage the closing of more schools of nursing and encourage the development of more schools of nursing to be organized within the State.

Respectfully submitted,
MAURICE M. HOELTGEN, M. D.,
*Chairman.*

THE PRESIDENT: This supplementary report will be referred to Reference Committee "E", Dr. James H. Hutton, Chairman.

## POSTGRADUATE EDUCATION

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

This Committee met twice during the 1955-56 fiscal year to consider plans for increasing attendance at conferences. During the summer and fall of 1955, the secretary sent letters to councilors and committee members, asking them to ascertain from their county medical societies dates and sites for meetings. To facilitate the transmittal of information needed by the Chicago and Monmouth offices, a mimeographed form was sent to societies requesting a conference. The Committee asked that dates be set up as far in advance as possible. and that more meetings be scheduled for the fall months. In April there was a conference scheduled for every week, and some of these dates were selected on very short notice. Since part of the Monmouth staff attends these meetings, and the amount of detail work done by the Chicago office in connection with arranging a conference is heavy, too many meetings in April, unless arranged far in advance, make it difficult for the best planning of the program.

The Committee arranged twelve meetings during the year—eleven large conferences, and one small conference. A chart is presented showing the place, attendance. number of speakers, counties covered, and the participating school or hospital.

There were two innovations this year. The meeting at Jacksonville was a combined meeting of Districts 5 and 6, and the meeting at Monmouth was arranged in cooperation with the faculties of two schools.

The following is the Chicago office procedure in handling the detail in connection with the preparation of a program:

1) a detailed letter to the county secretary, or program chairman, outlining the necessary arrangements to be made by him, 2) a letter to the secretaries of the surrounding counties, telling them of the meeting, and asking them to publicize the meeting by word of mouth, 3) a detailed letter of instructions to the person who is responsible for arranging the scientific portion of the meeting, 4) preparing the program for printing, 5) letters to the speaker confirming the engagement, giving travel information, asking if there is any special equipment needed, and making the necessary travel reservations. 6) a letter of thanks to the person who arranges the scientific program, 7) preparing a release for all weekly and daily papers in the county and surrounding counties where the meeting is held, 8) preparing a release for the Chicago Medical Society Bulletin and the Illinois Medical Journal.

In addition to this, the Monmouth office sends a letter to each member in the surrounding counties, inviting them to attend the meeting. Ten days before the meeting, these same people are sent a printed program, with a return post card, addressed to the secretary of the host society to determine the approximate number who expect to be present. Dr. Camp's office, at the request of the Council, is usually charged with the duty of making a guarantee to the hotel or club serving the dinner. No guarantee should be made until the middle of the afternoon during the conference, at which time a more accurate figure of those remaining for dinner can be determined.

In view of the amount of planning and the cost incident to a postgraduate conference, it is recommended that the dates selected be checked carefully for conflicts with other meetings before they are submitted. There were far too many conflicts this past year, as evidenced by the attendance records. The

POSTGRADUATE EDUCATION PROGRAM
1955-1956

| *Date* | *Place* | *Attend.* | *Dist.* | *No. Speakers* | *Counties Covered** | *Staff or Faculty* |
|---|---|---|---|---|---|---|
| 1955 | | | | | | |
| 10-20 | Vandalia | 36 | 7 | 7 | 10 | Veterans Administration Hospital, Hines |
| 10-27 | Sterling | 57 | 2 | 11 | 9 | Loyola University Stritch School of Medicine |
| 11-10 | Taylorville | 36 | 7 | 7 | 7 | University of Illinois College of Medicine |
| 11-17 | Anna | 23 | 10 | 7 | 7 | Veterans Administration West Side Hospital<br>University of Illinois College of Medicine |
| 1956 | | | | | | |
| 1-20 | Olney (small) | 36 | 8 | 6 | 7 | Henrotin Hospital |
| 3-7 | Effingham | 41 | 7 | 6 | 9 | Wesley Memorial Hospital |
| 3-21 | Elmhurst | 70 | 11 | 7 | 5 | Loyola University Stritch School of Medicine |
| 3-22 | Jacksonville | 56 | 5-6 | 8 | 13 | St. Luke's Hospital |
| 4-5 | Belleville | 65 | 10 | 4 | 7 | Northwestern University Medical School<br>and University of Illinois College of Medicine |
| 4-12 | Monmouth | 100 | 4 | 10 | 12 | Passavant Memorial Hospital |
| 4-19 | Decatur | 70 | 7 | 12 | 7 | Cook County Graduate School of Medicine |
| 4-26 | Mattoon | 92 | 8 | 6 | 10 | The Postgraduate School of Cook County Hospital |

* *A news release was prepared for the daily and weekly papers in the Councilor Districts.*

programs are well planned by the participants, but the Monmouth and Chicago offices are dependent on the local county medical societies, through their councilors and postgraduate education committee members, to select the best dates for their meetings.

The Committee recommends:

That there be more combined meetings of two or more councilor districts, that more requests for programs combining school and hospital staffs be received, and since the Committee is fortunate in having the splendid cooperation of the teaching schools and hospitals, that the sites selected should have good railroad transportation schedules to and from Chicago.

Respectfully submitted,
LOUIS R. LIMARZI, M. D.,
*Chairman.*
GEORGE E. KIRBY, M. D.,
*Co-Chairman.*
J. H. MALONEY, M. D.
N. C. BARWASSER, M. D.
JOSEPH J. GRANDONE, M. D.
JACOB E. REISCH, M. D.
F. W. SIEGERT, M. D.
WILLIAM H. SCHOWENGERDT, M. D.
MAX SAMTER, M. D.
N. A. THOMPSON, M. D.
PAUL S. BAUR, M. D.
EDWIN F. NECKERMAN, M. D.
WAYNE FLORA, M. D.
R. C. OLDFIELD, M. D.
JOHN LESTER REICHERT, M. D.
FREDERICK SELFRIDGE, M. D.
*Postgraduate Education Committee.*

## RURAL MEDICAL SERVICE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Committee on Rural Medical Service has continued its interest in the Farmer-Doctor Loan Fund Board pattern. Each year sees an increasing number of young men finishing their military service and settling back in their home areas of our state. Each year sees the recruitment of from seven to ten rural young men into our loan contract pattern.

The Loan Fund Board has sustained no financial losses incident to loaning funds to these young men. The tremendous amount of community good that has resulted and will result from this "education for need" program is hard to appraise. We hear from nearly everyone concerned with the program that this represents a most elemental solution to a desperate problem.

An increasing number of cities and villages, as well as entire counties, are adopting the Grade A program, so far as the milk quality is concerned.

An increasing number of cities are fluoridating their water supplies. This simple mechanism certainly will protect the dental health of many of our children yet unborn.

There is an increasing interest in environmental sanitation in all of rural Illinois, and anyone who follows the Department of Vital Statistics and the Health Department can see the value of everyone's continuing educational approach to these problems.

Except for a continuing pattern of public education directed at rural and village folk, the committee has no suggestions to make.

Respectfully submitted,
HARLAN ENGLISH, M. D.,
*Chairman.*
J. C. REDINGTON, M. D.
G. C. OTRICH, M. D.
E. P. COLEMAN, M. D.
*Committee on Rural Medical Service.*

DR. HARLAN ENGLISH: I have a supplementary report.

MR. CHAIRMAN AND MEMBERS OF THE HOUSE OF DELEGATES:

The future of this country may be decided within the next week. It is for this reason that I am presenting this petition to you. Tomorrow afternoon in the Senate of the United States the report of Senator Byrd's Committee on H. R. 7225 will be presented. An effort will be made to put doctors, senators and representatives and everybody else right in the middle between disabled people and those under Social Security. It is felt that instead of sending individual telegrams to Senators, Representatives and the President, we return to the fundamental right of petition. I will read the petition that was prepared this morning and presented to the Council and signed by each member of the Council. When I finish reading, I will ask the House to concur and sign the petition. We will send it to the President, Dwight D. Eisenhower, Marion B. Folsom, Secretary of Health, Education and Welfare, and all elected senators and representatives from the great state of Illinois.

It reads as follows:

Hon. Dwight D. Eisenhower, President of the United States
Hon. Marion B. Folsom, Secretary of Health, Education and Welfare
Hon. Senators and Representatives of the Great State of Illinois

Sirs:

WHEREAS, no adequate and unbiased study of the nature, cost, and scope of the Social Security System and its economic, social and political impact on the American people has been made, and

WHEREAS, until such facts, medical and otherwise, are developed, we urge you to stand firm against any attempt to reinstate disability benefits to H. R. 7225, and

WHEREAS, no person in Illinois is suffering from lack of care because of disability, and

THEREFORE BE IT RESOLVED, that the physicians comprising the Illinois State Medical Society, represented by their elected delegates now assembled, respectfully request that you honor this petition.

Respectfully submitted,
HARLAN ENGLISH, M. D.,
*Chairman.*

DR. ENGLISH: I move a request that the House of Delegates agree to this petition. (Motion seconded by Dr. J. M. Pfeiffenberger, Madison County)

THE PRESIDENT: This can be acted on without turning it over to the Reference Committee by a two-thirds vote of the House. Is there any discussion? There is no discussion and the question is called for. (Motion unanimously adopted).

DR. ENGLISH: It is important that you sign your home address. You are petitioning this as a citizen.

THE PRESIDENT: We will continue with the reports.

## SCIENTIFIC SERVICE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Twenty-two county medical societies, including three branch societies, used the facilities of the Scientific Service Committee during the past year. Seventy-five speakers were scheduled; in addition ten speakers have been invited for forthcoming programs.

The societies requesting were: Bureau, Champaign, DeKalb, Ford, Greene, Iroquois, Kankakee, Kane, Knox, LaSalle, Marion, McDonough, Montgomery and Macoupin, who meet jointly, Tazewell, Wayne, and Whiteside and Lee, who also hold combined meetings. Branch societies were Douglas Park, Englewood, and Stock Yards.

With the exception of the branch societies, return reservation cards and notices of meetings were mailed from the Chicago Office, as was publicity to newspapers, not only in the town where the meeting

was held, but also to those in adjacent counties.

The county medical societies have always been billed to pay for the cost of postal cards used for the notices of their meetings; however, in the past few months a new arrangement was inaugurated. The societies are now asked to send payment direct to the office of Dr. Harold M. Camp, Secretary of the Illinois State Medical Society, Monmouth. The purchase of new supplies of postal cards is now financed out of Petty Cash funds in the Chicago Office.

It is interesting that two program chairmen for staff meetings in Chicago hospitals requested assistance. This could not be provided, because of the ruling of the Joint Commission on Accreditation of Hospitals which stipulates that the monthly staff meetings must be handled by the hospital staff itself.

The Scientific Service Committee held a meeting October 4, 1955, to consider the response to a letter offering assistance to all county medical societies. This letter, dated August 25, 1955, went to those county societies not regularly serviced by the Committee. Some of the larger societies, such as Lake, Macon and Winnebago, arrange their own programs, while others, smaller in membership, attend meetings of adjacent county societies, or depend on the Illinois Academy of General Practice programs; other societies replied that the practice of regular meetings was difficult because of their very small membership.

One large society secretary requested assistance with speakers, but then proceeded to invite his own speakers. This created confusion, not only in the Chicago Office where the invitations are issued, but also to the speakers who were receiving two invitations for different dates. This, the Committee hopes, has been corrected.

Numerous letters of appreciation for the caliber of the speaker have been received this past year. This is particularly gratifying, since many of them were comments on some of the younger physicians who cooperated in the activities of the Scientific Service Committee.

More speakers from the downstate areas were used in the past year. This is another satisfaction to the Committee, since it has, for years, urged county medical societies to ask for out of Chicago physicians when they planned programs.

The Committee has always encouraged those physicians living outside of Chicago to make themselves available for talks to county societies.

Some societies consistently request assistance on a short notice basis. This is a difficult condition to control. In all but one instance, however, the request was fulfilled that is a speaker was obtained, but the time element involved prohibited the mailing of meeting notices and newspaper publicity.

The Committee regrets that, while work on the proposed revision of Speakers has progressed to a slight degree, the culmination is nowhere in sight. While hundreds of new names have been included in the Speaker's File in the Chicago Office, these are not in the hands of the Secretary or Program Chairman of the County Medical Society. The 1947 revision is obsolete.

The Committee hopes that during the summer months when some of its work lightens because regular county society meetings are not held, the details incident to bringing out an up-to-date list of Speakers can be expedited.

Your Chairman has attended all meetings of the Council during the past year and has presented a report at every meeting of the Council, a copy of which has been sent to each member of the Committee.

The Committee has attempted to meet all its obligations, but it recognizes that its failure to bring out a Revised List of Speakers is a sad omission.

In submitting this report, the Scientific Service Committee expresses its gratitude to the Council and to the House of Delegates for their continued confidence.

Respectfully submitted,
Louis R. Limarzi, M. D.,
*Chairman.*
J. K. Hanson, M. D.
William H. Whiting, M. D.
Gilbert Marquardt, M. D.
Jerome T. Paul, M. D.
Harry A. Oberhelman, M. D.
Charles D. Krause, M. D.
Max Hirschfelder, M. D.
*Scientific Service Committee.*

## TUBERCULOSIS CONTROL

To the Members of the House of Delegates:

The Tuberculosis Control Committee of the Illinois State Medical Society held a formal committee meeting in Springfield, Illinois, in the offices of the Director of the Illinois State Public Health Department. The objective of the committee was to study the problem of the recalcitrant tuberculous patients. It is the considered opinion of the committee that since there are sufficient beds for all, or nearly all, active cases of tubercuosis in Illinois the problem of the recalcitrant patient should be attacked more vigorously than it has been in the past in Illinois.

Since 1948, 22 states and 2 territories have passed legislation for the isolation of the recalcitrant tuberculosis patient. It is very interesting to note that the legislature of New York provided for the compulsory hospitalization of tuberculosis patients as early as 1913.

A review of a recent study made by the National Tuberculosis Association indicates that there is a great deal of variability as to how these laws are applied in different states. The State of California committed 119 patients from 1950 through 1954.

The majority of the committee was of the opinion that the present laws for handling communicable diseases in the State of Illinois are adequate to take care of the recalcitrant tuberculosis patient in Illinois except for one provision, i. e., at the present time there are no security beds available for the hospitalization of such recalcitrant patients in the State.

The committee explored with Dr. Cross—

1. The possibility of utilizing some local tuberlosis sanitarium with sufficient vacant beds to care for a small number of recalcitrant patients, if the Glackin Act could be changed in such a manner to permit this.
2. The court could give the recalcitrant tuberculous patient the alternative of going to a local tuberculosis sanitarium or the prison for misdemeanants at Vandalia (from Vandalia they could be transferred upon request to the State Prison Tuberculosis Hospital at Pontiac).
3. To build security beds, an estimated 30, as an addition to the Chicago State Tuberculosis Hospital.

The statistics on tuberculosis mortality and morbidity for the State of Illinois are not yet available for 1955. Incomplete figures presented by Dr. Clifton Hall, Director of the Division of Tuberculosis of the Illinois State Public Health Department, indicated that there would be a further decline in the death rate for the State of Illinois as a whole; for the Chicago and Suburban Cook County District, as well as most of the remaining counties of the state.

The committee studied the figures of the United States Public Health Service which definitely shows a marked decline in the death rates for tuberculosis in the country as a whole. The tuberculosis mortality figures for the State of Illinois approximate the rate for the country as a whole.

The United States Public Health figures for Illinois reports a decline in mortality rate of 58.6 per cent from 1947 to 1953. The death rate for Illinois was 14 per 100,000 in this period. It is predicted that the 1955 mortality rate will be 10½ or 11 per 100,000. There were 34 states in the union with a lower rate. This group included such states as Michigan, Ohio and California.

On the basis of percentage of mortality decline from 1947 to 1953, Illinois ranked 42nd among the 48 states, for the years from 1947 to 1953.

In Illinois and in the country as a whole there has been no decline in the number of newly reported cases. This means then that there are an increasing number of cases accumulating in the country who will require close observation and care for the rest of their lives.

A favorable showing was made by the State of Illinois in the total number of people x-rayed in the various survey programs conducted throughout the State. The State was among the first ten with 15.2 per cent of the population x-rayed.

The Committee presents these figures in order to bring out the fact that tuberculosis control in the State of Illinois is far from complete.

Since the last meeting of the House of Delegates a new state law requiring all school employees to be x-rayed has gone into effect.

In Chicago, the Chicago Health Department issued a ruling in October, 1955, requiring annual x-rays on all food handlers. This has increased the number of newly reported cases in Chicago to the point that there is a waiting list for admission at the Chicago Municipal Tuberculosis Sanitarium.

During the last year a program of routine x-raying of all inmates and employees at Cook County jail has been undertaken with the cooperation of the United States Public Health Service, the Chicago Municipal Tuberculosis Sanitarium, the Tuberculosis Institute of Chicago and Cook County, and the Cook County Institutions.

During the first six months of this operation 109 cases were diagnosed as tuberculosis, 70 of which were active or possibly active disease and 39 were arrested or inactive. Of 9,303 film taken during this period there were 173 cases showing pathology of which 109 were diagnosed as tuberculosis. A similar program has been in effect at the Bridewell under the supervision of the Chicago Municipal Tuberculosis Sanitarium.

The committee would like to make the following recommendations to the House of Delegates:

1. That the Delegates of the Illinois State Medical Society should take an active part in persuading the local County Medical Societies to take a more active part in the tuberculosis case finding. They can do this most effectively by routine chest x-rays on all patients that they see in their offices and hospitals.
2. They further recommend that the Delegates persuade the local County Medical Societies to take an active part in setting plans for routine admission chest x-rays in all hospitals in their respective localities.

It is the considered opinion of the committee that this is a most important step in the control of tuberculosis that can be taken in the State of Illinois, and that if the members of the House of Delegates will carry out this recommendation Illinois will come a long step forward towards the complete eradication of this outmoded and unnecessary disease.

3. The committee further requests the House of Delegates of the Illinois State Medical Society recommend to the Illinois State Health Department that it take active and definitive measures to provide security beds for the recalcitrant tuberculosis patients in the State of Illinois, and that this request be transmitted to the Governor of the State of Illinois and to the Medical Director of the Illinois State Health Department by the Secretary of the Illinois State Medical Society.

George C. Turner, M. D.
*Chairman*
E. A. Piszczek, M. D.
Wm. Bryan, M. D.
L. L. Fatherree, M. D.
Herbert Rattner, M. D.
Darrell Trumpe, M. D.
Winston Tucker, M. D.
Charles Petter, M. D.
Bernard Klein, M. D.
James H. Hutton, M. D.
*Committee on Tuberculosis Control.*

## VOLUNTARY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE

To the Members of the House of Delegates:

The Committee notes continued progress in the simplification of credit forms used in connection with the filing of applications for benefits to be obtained from the majority of insurance companies. This improvement will result in the elimination of a considerable amount of paper work on the part of the physician, but at the same time a fact that must not be lost sight of is that it is necessary for the insurer to obtain proof of a patient's claim before benefits can be paid. The sale of insurance contracts, as well as marked improvement so far as coverage is concerned, has been noted throughout Illinois during the past year. Figures for 1955 are not yet available, but at the beginning of 1955 approximately 5½ million people were covered under policies approved for participation in the Illinois plan.

The Blue Shield Plans throughout the State of Illinois during the year 1955 showed considerable progress. These plans operate throughout the state, some of them limiting their efforts to essentially local areas, while Rockford Blue Shield Plan and Illinois Medical Service, (which was originally the Blue Shield Plan of the Chicago Medical Society) operate in many counties. Illinois Medical Service is now operating in about 93 of the 102 counties of the state.

The Blue Shield Plan at Rockford (Northern Illinois Medical Service Corporation) had 65,006 members as of December 31, 1955, including 24,095 subscribers and 40,911 dependents. It has 0.70% of the 9,297,000 population of the state enrolled, down from 0.76% a year previous. Its assets totalled $340,974 and reserves $188,922. Its total earned subscription income was $458,672, of which it paid out $316,482 in medical and surgical benefits. Operating expense was $81,861 or 17.85%.

At Moline and Alton the Blue Shield groups showed similar progress. Moline (Rock Island County Medical Service) had 28,149 members, 11,754 subscribers and 16,395 dependents. It was serving 0.30% of the entire state population, down from 0.32 per cent the previous year. Assets totalled $176,949 and reserves $112,103. Total earned subscription income was $341,915, of which it paid out in benefits $266,032. Operating expense was $46,207 or 13.51 per cent.

Alton (Medical-Surgical Service of Illinois) had 25,065 members, 10,837 subscribers and 14,228 dependents. It was serving 0.27% of the entire state population, compared with 0.24 per cent in 1954. Assets totalled $112,734 and reserves $46,776. Total earned subscription income was $195,198, of which it paid out $157,851 at an operating cost of $37,890 or 19.41%.

The Blue Shield Plan of Illinois Medical Service, with headquarters in Chicago, reports the folowing figures as of December 31, 1955:

| | |
|---|---|
| Total membership | 1,274,443 |
| Percentage of entire state | 13.7% |
| Added in 1955 | 189,870 |
| Percentage of increase | 17% |
| Income from Members | $11,623,003.40 |
| Benefits paid (to M. D.'s) | $9,836,672.46 |
| Number of services involved | 212,583 |
| Operating Costs (Dec.) | 7.82% |
| Assets | $9,395,555 |
| Increase in 1955 | $1,181,046 |
| Percentage of increase | 10% |
| Reserves (unallocated) | $6,650,771.08 |
| 1955 increase | $950,765 |
| Per member | $5.40 |

Late in 1955, this Blue Shield Plan offered a new certificate....known as Series "C"....which will provide many substantially increased allowances over those which have been offered in the past by the General Certificate. This Series "C" Certificate is in addition to....but does not supplant....the General Blue Shield Certificate. This new Series "C" Plan will be offered in answer to a public demand from certain groups who desire a higher schedule for payments to physicians. Members, of course, pay higher dues for Series "C" membership than they do for the General Certificate.

Another forward step was the offering (jointly with Blue Cross) of a non-group enrollment during a two-week period in April, 1956....which gave people under 65 and in good health an opportunity to join on an individual basis.

Another recent accomplishment is the development of a Special Extended Benefits program which will provide up to 2 years of special allowances for in-hospital medical care for each different and unrelated illness or accident. This Extended Benefit program goes into effect after a member has used up the regular in-hospital benefits under his basic certificate. Thus, beginning with the doctor's 71st visit to see members in the hospital....Extended Benefit allowances are provided of $3 per hospital visit for up to 4 visits per week and may continue for up to 2 years if a member must remain in the hospital that long. This is also a joint offering with Blue Cross.

While the growth of the Voluntary Prepayment Plan movement in Illinois has been very steady, further growth an expansion into other fields is still necessary. It is equally true that while insurance is designed to help people pay their medical bills, it definitely is not an excuse for a physician to increase his charges. Too much emphasis cannot be placed on this statement, because of the increase in sales of the so-called major medical expense benefit contracts, which are frequently such that no definite fee or benefit may be indicated, and it is presumed the physician will charge a fee commensurate with the patient's ability to pay, as well as with the type of service performed. In other words, it is anticipated his usual fee is the one that will prevail.

The Committee has noted with interest proposed legislation for insurance to cover government employees, as well as military dependents, and it is entirely possible that the Illinois State Medical Society may be called upon to make a major decision in the near future in connection with such proposed legislation.

Respectfully submitted,
PERCY E. HOPKINS, M. D.
*Chairman*
WARREN W. FUREY, M. D.
*Vice-Chairman*
JACOB E. REISCH, M. D.
DAVID B. FREEMAN, M. D.
CARL E. CLARK, M. D.
THOMAS J. KELLY, M. D.
*Ex-Officio*:
F. GARM NORBURY, M. D.
JOSEPH T. O'NEILL, M. D.
HAROLD M. CAMP, M. D.
*Committee on Voluntary Prepayment Plans for Medical and Surgical Care.*

### POLIO VACCINE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Committee on Poliomyelitis Vaccine of the Illinois State Medical Society was appointed to keep the Council informed on the complicated and often confused situation in poliomyelitis vaccine distribution in Illinois, and on state and national developments in the vaccine program. The committee also has been able to interpret the opinions of the Council to the Department of Public Health through the three members of the Council committee on the Vaccine Distribution Committee, and the member who is on the Technical Advisory Committee to the Department of Public Health. There is close cooperation between these groups and the situation can best be described as being as well as can be expected. As vaccine becomes more plentiful the constructive efforts of all of the agencies involved should become more apparent.

JOHN LESTER REICHERT, M. D.
*Chairman*
THEODORE R. VANDELLEN, M. D.
JOSEPH T. O'NEILL, M. D.
JAMES A. CONNER, M. D.
*Committee on Poliomyelitis Vaccine.*

THE PRESIDENT: I will call on Dr. Frank Fowler, Chairman of the Joint Committee on Arrangements, if he has any report.

DR. FOWLER: Please buy banquet tickets.

THE PRESIDENT: I want to thank you, Dr. Fowler, and your Committee for the excellent arrangements for this meeting.

The next item will be new business, since the Secretary tells me there is no unfinished business. Under new business the first thing will be introduction of resolutions and referral to the proper Reference Committee. I would ask that unless it is extremely vital that the presenter read only the enacting clause and the "be it resolved." The following resolutions have been printed in the Handbook, and will be referred without reading to the proper Reference Committees, as follows:

The first one from the Perry County Medical Society will be referred to Committee "B". This appears on Page 140.

## RESOLUTIONS

### PERRY COUNTY MEDICAL SOCIETY

WHEREAS, Since 1950 the United Mine Workers Welfare and Retirement Fund, with the help of the component Medical Societies of the State of Illinois and the sanction of the Illinois State Medical Society, has achieved an enviable record for the care of its recipients under an ethical arrangement including free choice of physicians and surgeons, and in Perry County surgeons are and have been doing only that surgery which comes well within their ability with those procedures outside their ability having been referred to specialists of note; and

WHEREAS, the Area Administrator of the Fund has never utilized the legally constituted grievance committee of the Perry County Society to complain about the quality of surgical and medical care in this county; and,

WHEREAS, The administrator of the Fund recently presented the Perry County Medical Society with an ultimatum whereby all elective surgical procedures for beneficiaries of the Fund shall first receive a compulsory consultation with a surgeon of the Fund empowered to decide whether to do the surgery himself; and

WHEREAS, The Perry County Medical Society feels that such a program would be unethical and, in fact, a direct violation of the patients' free choice of surgeons and the surgeon's free choice of consultation.
BE IT THEREFORE RESOLVED: That the United Mine Workers Welfare and Retirement Fund which has repeatedly stressed that they desire utilization of the best *available* facilities, recognize and accept such surgery as performed only by those surgeons deemed qualified in the procedure by the Senior Surgical Committee of the Marshall Browning Hospital in DuQuoin, Illinois.

This resolution was adopted by a unanimous vote of the Perry County Medical Society, 31 January 1956.

BYFORD I. HALL, M. D.,
*President Perry County Medical Society.*
H. I. STEVENS, M. D.
*Secretary Perry County Medical Society.*

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THE PRESIDENT: The resolution from Macoupin County on Page 140, will be referred to Committee "B".

MACOUPIN COUNTY MEDICAL SOCIETY

WHEREAS, A recent directive of the U. M. W. Welfare Fund states that only physicians who are members or are eligible for membership in the American Board of Surgery or the American College of Surgeons may be placed on the qualified surgical list of Welfare Surgeons and
WHEREAS, surgical qualifications in accredited hospitals is determined by credential committees in said hospitals, and
WHEREAS, the above policy and directive of the U M W A Welfare Fund does not permit eligible recipients of the Fund a free choice of surgeons as well as being discriminatory to the qualifications of physicians,
THEREFORE BE IT RESOLVED, that the members of the Macoupin County Medical Society protest this policy and directive of the U M W A Welfare Fund and requests that its members be granted the opportunity for participating in the Fund's surgical program in accordance with surgical privileges granted them by the credential committees of St. John's and Memorial Hospitals, Springfield, Illinois, Area Hospital, Carlinville, Illinois, Community Memorial Hospital, Staunton, Illinois, and St. Francis Hospital, Litchfield, Illinois.

This resolution was adopted at a Regular Macoupin County Medical Society Meeting on January 24, 1956 with no dissenting votes.

JOSEPH J. GRANDONE, M. D.,
*Secretary-Treasurer Macoupin County Medical Society.*

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THE PRESIDENT: The resolution from the LaSalle County Medical Society, Page 141, will be referred to Committee "B".

LASALLE COUNTY MEDICAL SOCIETY

WHEREAS, a recent directive of the UMWA Fund states that only physicians who are members or are eligible for membership in the American Board of Surgery or the American College of Surgeons may be placed on the qualified surgical list of Welfare surgeons, and
WHEREAS, surgical qualifications in accredited hospitals is determined by credential committees in said hospitals, and
WHEREAS, the above policy and directive of the UM WA Welfare Fund does not permit eligible recipients of the Fund a free choice of surgeons as well as being discriminatory to the qualifications of physicians,
THEREFORE BE IT RESOLVED: That the members of the LaSalle County Medical Society protest this policy and directive to the UMWA Fund and requests that its members be granted the opportunity of participation in the Fund's surgical program in accordance with surgical privileges granted them by the credential committees of our respective hospitals.

This resolution was adopted at a Regular La Salle County Medical Society Meeting on February 9, 1956.

RALPH J. BAILEY, M. D.,
*Secretary-Treasurer La Salle County Medical Society*

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THE PRESIDENT: The resolution presented by Dr. D. M. Roberts, on the bottom of Page 141, will be referred to Committee "A".
WHEREAS, It is recognized that there is a great problem confronting the Medical Profession, as well as the general public, in the form of "Old Age Assistance Program," and
WHEREAS, There has been an improvement in the method of handling these cases, especially the method of and the amount of payment per case, during the past few years, and
WHEREAS, We realize there are still many problems requiring further attention and study, such as the following particular problem, the arbitrary rule of limiting the number of hospital visits to ten (10) in any one acute sickness, these being daily visits,, and then regardless of how acute the condition may be, the physician is limited to payment after the first ten to two visits per week, regardless of the number of times he may be required to see the patient, and
WHEREAS, In many cases the condition may remain critical or serious and require constant attention for a longer period of time beyond the ten day period of allowed time, and
WHEREAS, It should be permissible for the physician to receive payment for the necessary period of acute attention, therefore
BE IT RESOLVED, That the members of the Congress of Delegates to the Illinois Academy of General Practice being assembled in Annual Session at Springfield, Illinois, on the twenty-fifth day of October, 1955, give serious consideration to the above problem which confronts each one of us; and
BE IT FURTHER RESOLVED, That a recommendation be made to allow exceptions to the general rule, where acute cases require more than the ten day allowed attention so that the patient can and will receive the necessary care, and at the same time the physician be be paid for this additional care; and
BE IT FURTHER RESOLVED, That the physician caring for such cases requiring additional acute care make a report to the State committee in support of such needed attention; and
BE IT FURTHER RESOLVED, That this resolution be forwarded to the House of Delegates of the Illinois State Medical Society with a request that it be sent to the proper State Committee handling the Old Age Assistance Program for further study and recommendation, to those in authority.

D. M. ROBERTS, M. D.

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THE PRESIDENT: The resolution at the bottom of Page 142 in regard to Alternate Delegates to the A. M. A. will be refererd to Committee "A".

ALTERNATE DELEGATES TO THE A. M. A. ATTENDANCE AT MEETINGS

WHEREAS, The volume of work connected with the meetings of the House of Delegates of the American Medical Association continues to become greater and more diversified each year: and
WHEREAS, The Delegates to the American Medical Association from Illinois State Medical Society have been consistently honored by being appointed to Reference Committees; and
WHEREAS, Such appointments frequently preclude attendance at hearings of other Reference Committees by the Delegates from the Illinois State Medical Society; and
WHEREAS, The Alternate Delegates to the American Medical Association from the Illinois State Medical Society, if in attendance, could enjoy many of the

privileges and perform some of the duties of Delegates, in addition to becoming familiar and experienced with the manner in which the House of Delegates operates; and

WHEREAS, Such experience gained by the Alternate Delegates could be very beneficial to the Illinois State Medical Society as well as to the American Medical Association; now therefore be it

RESOLVED, That at least one half the total number of of Alternate Delegates to the American Medical Association from the Illinois State Medical Society be requested to attend each meeting of the House of Delegates of the American Medical Association after being designated to perform this duty by the Chairman of the Council, and be it further

RESOLVED, That the House of Delegates of the Illinois State Medical Society hereby recommends to the council of the Illinois State Medical Society that the designated Alternate Delegate be reimbursed at the same rate used in calculating allowances for the Delegates.

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THE PRESIDENT: The resolution from Randolph County on Page 143, will be referred to Dr. Whiting's Committee on Reports of Standing Committees. The second resolution from Randolph County on Page 144, and the third one from Randolph County, Page 144, will be referred to Committee "B".

RANDOLPH COUNTY MEDICAL SOCIETY

WHEREAS, at the present time there are many chiropractors practicing their vocation in the State of Illinois without license and

WHEREAS, convictions of said chiropractors for practicing without license are extremely difficult to obtain and

WHEREAS, even if conviction is obtained the punishment is minimal

THEREFORE BE IT RESOLVED, that the members of the Randolph County Medical Society protest this laxness in law enforcement and request that the Illinois State Medical Society recommend to the legislature of the State of Illinois such modifications to the present law governing the practicing of chiropractic in the State of Illinois so that it would be easier to obtain conviction for practicing without a license and secondly that if such conviction were obtained the punishment for such illegal practice would be more in keeping with the punishment given to doctors of medicine practicing without license.

This resolution was adopted at a Regular Randolph County Medical Society Meeting on January 26, 1956 with no dissenting votes.

F. P. GAUNT, JR. M. D.
*Secretary Randolph County Medical Society.*

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RANDOLPH COUNTY MEDICAL SOCIETY

WHEREAS, the present licensure law for the practice of medicine in the State of Illinois does not require American citizenship for licensure and

WHEREAS, the same present licensure law does not require graduation from a grade A medical school or its equivalent,

THEREFORE BE IT RESOLVED, that the members of the Randolph County Medical Society protest this deficiency and request that the Illinois State Medical Society recommend to the legislature of the State of Illinois the following changes in the licensure law for the practice of medicine and surgery.

FIRST, that only American citizens be licensed to practice medicine and surgery in the State of Illinois.

SECOND, that an applicant for licensure in the State of Illinois must be a graduate of a grade A medical school or its equivalent.

This resolution was adopted at a Regular Randolph County Medical Society Meeting on January 26, 1956 with no dissenting votes.

F. P. GAUNT, JR. M. D.,
*Secretary Randolph County Medical Society.*

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RANDOLPH COUNTY MEDICAL SOCIETY

WHEREAS, Since 1950 the United Mine Workers Welfare and Retirement Fund, with the help of the component Medical Societies of the State of Illinois and the sanction of the Illinois State Medical Society, has achieved an enviable record for the care of its recipients under an ethical arrangement including free choice of physicians and surgeons and in Randolph County surgeons are and have been doing only that surgery which comes well within their ability with those procedures outside their ability having been referred to specialists of note; and

WHEREAS, a recent directive of the UMWA Welfare Fund states that only physicians who are members or are eligible for membership in the American Board of Surgery or the American College of Surgeons may be placed on the qualified surgical list of Welfare surgeons, and

WHEREAS, the UMWA Welfare Fund has made no effort in the past to bring any grievance against a particular physician to the attention of the grievance committee of the county medical society to which that particular physician belongs and

WHEREAS, the recent directive of the UMWA Welfare Fund does not permit eligible recipients of the fund a free choice of surgeons and

WHEREAS, surgical qualifications in hospitals is determined by credential committees in said hospitals, and

WHEREAS, the UMWA has refused in several instances to deal with several hospitals for ordinary care of patients,

THEREFORE BE IT RESOLVED, that the members of the Randolph County Medical Society protest this past policy of the UMWA Welfare Fund and the recent directive of the Welfare Fund and request that its members be granted the opportunity for participation in all branches of the UMWA Welfare Fund program in accordance with privileges granted them by the credential committees of the hospitals in Randolph County and furthermore request that in the future the UMWA Welfare Fund present any grievances against any particular doctor to the grievance committee of the respective physician's county medical society.

This resolution was adopted at a Regular Randolph County Medical Society Meeting on January 26, 1956 with no dissenting votes.

F. P. GAUNT, JR. M. D.,
*Secretary Randolph County Medical Society.*

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THE PRESIDENT: The resolution from the Will-Grundy County Medical Society, Page 145, will be referred to Committee "B".

WILL-GRUNDY COUNTY MEDICAL SOCIETY

WHEREAS, recent directives from the United Mine Workers of America Health and Welfare Fund have become extremely discriminating and restricting to both the Mine Member and to the family Physician as to the amount of Care to be given by the family Physician and to the choice of Consultant in an area where free choice of a Physician and Consultant is the accepted patient privilege it appears unwise to have one small group consistently violating the principle. Specifically a directive demands that surgical cases be taken over by certain Certified Surgeons specified by the Fund to the exclusion of other qualified Surgeons in the Community.

BE IT RESOLVED THAT, we consider this practice a definite deterrant to the quality of care received by the patient.

If this attitude is not CHANGED we feel the ENTIRE situation should be appraised from the view-

point of Medical Ethics.

This Resolution was adopted by the Will-Grundy County Medical Society at a regular meeting on April 12, 1956 with no dissenting votes.

D. J. Baima, M. D.,
*Secretary Will-Grundy County Medical Society.*

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THE PRESIDENT: The resolution from the Jefferson-Hamilton County Medical Society, Page 146, will be referred to Committee "B".

JEFFERSON-HAMILTON COUNTY MEDICAL SOCIETY

Whereas, a recent directive of the UMWA Welfare Fund states that only physicians who are members or are eligible for membership in the American Board of Surgery or the American College of Surgeons may be placed on the qualified surgical list of Welfare surgeons, and

Whereas, surgical qualifications in accredited hospitals are determined by credential committees in said hospitals, and

Whereas, the above policy and directive of the UM WA Welfare Fund does not permit eligible recipients of the Fund a free choice of surgeons as well as being discriminatory to the qualifications of physicians,

Therefore Be It Resolved: that the members of the Jefferson-Hamilton County Medical Society protest this policy and directive of the UMWA Welfare Fund and request that its members be granted the opportunity for participation in the Fund's surgical program in accordance with surgical privileges granted them by the credential committees of Good Samaritan Hospital, Mt. Vernon, Illinois.

This Resolution was adopted at a Regular Jefferson-Hamilton County Medical Society Meeting on January 26, 1956 with no dissenting votes.

E. R. Geprian, M. D.
*President*
H. C. Rogers, M. D.
*Secretary*

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THE PRESIDENT: The resolution from the Kane County Medical Society, Page 146, will be referred to Committee "B".

KANE COUNTY MEDICAL SOCIETY

Therefore Be It Resolved, that the members of the Kane County Medical Society protest this policy and directive of the UMWA Welfare Fund and requests that its members be granted the opportunity for participation in the Fund's surgical program in accordance with surgical privileges granted them by the credential committees of the hospitals of Kane County, Illinois.

This Resolution was adopted at the Regular Kane County Medical Society Meeting on February 15, 1956 with no dissenting votes.

Morton Schaffran, M. D.,
*Secretary Kane County Medical Society.*

THE PRESIDENT: Are there other resolutions to be presented?

DR. HARRY E. MANTZ, Madison County: I have two resolutions from the Madison County Medical Society.

REQUIREMENTS FOR LICENSURE IN THE STATE OF ILLINOIS

Be it resolved, that we, the Madison County Medical society, believe that the caliber of medical attention to be given to the body politic should be maintained on a high level; that the requirements for obtaining a license to practice medicine in the State of Illinois should be:

1. That the applicant be a full citizen of the Unied States of America.
2. That the applicant be of good moral character.
3. That the applicant should have educational training embracing a high school diploma, a college education covering the basic sciences, and a medical degree followed by proper clinical training in a hospital in the United States of America.

Be it further resolved, that since these requirements do not exist at the present time in the State of Illinos, it is respectfully requested by the members of the Madison County Medical Society that the Illinois State Medical Society institute proceedings to effect the necessary legislation to bring about these requirements.

Respectfully submitted,
MADISON COUNTY MEDICAL SOCIETY
JOINT COMMITTEE ON HOSPITAL ACCREDITATION

Resolution adopted by the Madison County Medical Society at its regular meeting, April 5, 1956.

Whereas, the American Medical Association is a proven successful accreditation body in many fields, and

Whereas, the Joint Committee on Hospital Accreditation has not truly represented all of the physicians of this country as evidenced by the widespread criticism of this body by the membership of the American Medical Association,

Therefore be it resolved, that this House of Delegates request that the Delegates to the American Medical Association Convention in June, 1956, formulate and carry out a program at the June meeting designed to effect the dissolution of the Joint Commission and the formation of a Hospital Accreditation Committee of the American Medical Association to take its place.

THE PRESIDENT: These two resolutions from Madison County will be referred to the Reference Committee on Reports of Standing Committees, Dr. Whiting, Chairman.

The Chair recognizes Dr. C. Paul White, Henry County.

DR. C. PAUL WHITE: The following motion was presented by Dr. J. S. Puentes, seconded by Dr. B. M. Terry, and approved by the Henry County Medical Society at the May 9, 1956 meeting.

Whereas, the House of Delegates of the American Medical Association in 1947 resolved that "It was never intended that staff appointments in hospitals generally, or even in hospitals approved for residencies, should be limited to Board certified physicians as is now the policy in some hospitals. Such policies, if practiced extensively, are detrimental to the health of the people and therefore to American medicine. Hospital staff appointments should depend on the qualifications of physicians to render proper care to hospitalized patients as judged by the professional staff of the hospital and not on certification or special society membership."

Whereas, the House of Delegates of the American Medical Association on December 1, 1955, in Boston, Massachusetts, resolved "to discourage any arbitrary restrictions by hospitals against general practitioners as a group or as individuals."

Whereas, in the November 1, 1955 circular letter to participating physicians, the UMWA Welfare and Retirement Fund established, "Major surgery in all fields will be paid for only when performed by recognized specialists designated in the listing as surgeons."

Whereas, in principal, the UMWA Welfare and Retirement Fund policy is contradictory to the policy of the American Medical Association.

Whereas, this circular letter is against the right of the Hospital Medical Staff to decide who will have surgical privileges.

Whereas, this circular letter is an open attack to the free choice of medical care by the patient, and to the free practice of medicine.

The Henry County Medical Society has resolved:

1. To instruct its Delegates to the Illinois State Medical Society Convention May 15-18 to denounce the UMWA Welfare and Retirement Fund as violators of the policies of the American Medical Association.

2. To vote against any discrimination of the general practitioner as a group or as individuals.

3. To stand against the suppression of surgical privileges to general practitioners by the UMWA Welfare and Retirement Fund.

4. To stand for the right that the only body qualified to decide the surgical privileges of the physician is the Medical Staff of the Hospital where he practices.

5. To cooperate with the other delegates of the several County Medical Societies in Illinois that confront the same problem with the UMWA Welfare and Retirement Fund.

(Signed)
WILLIAM CARSON, M. D.,
*Secretary, Henry County Medical Society.*
C. PAUL WHITE, M. D.,
*Delegate from Henry County Medical Society.*

THE PRESIDENT: This resolution will be referred to Committee "B".

The Chair recognizes Dr. Darrell H. Trumpe from Sangamon County.

DR. DARRELL H. TRUMPE: This resolution was adopted at the regular Sangamon County Medical Society meeting on December 1, 1955, with no dissenting votes.

WHEREAS, a recent directive of the UMWA Welfare Fund states that only physicians who are members or are eligible for membership in the American Board of Surgery or the American College of Surgeons may be placed on the qualified surgical list of Welfare Surgeons, and

WHEREAS, surgical qualifications in accreditated hospitals are determined by credential committees in said hospitals, and

WHEREAS, the above policy and directive of the UMWA Welfare Fund does not permit eligible recipients of the Fund a free choice of surgeons as well as being discriminatory to the qualifications of the physicians,

THEREFORE BE IT RESOLVED, that the members of the Sangamon County Medical Society protest this policy and directive of the UMWA Welfare Fund and request that its members be granted the opportunity for participation in the Fund's surgical program in accordance with surgical privileges granted them by the Credential Committees of St. John's Hospital and Memorial Hospital, Springfield, Illinois.

(Signed)
WILLIAM DE HOLLANDER, M. D.,
*Secretary-Treasurer Sangamon County Medical Society*

THE PRESIDENT: This resolution will be referred to Committee "B".

I neglected to say that in reading the referred resolutions printed in the HANDBOOK, if any of the makers of these resolutions have comments to make, the floor is available. It would be my opinion that perhaps comments should be made before the Reference Committee. Almost certainly, anyone who sends a resolution to the House of Delegates should appear before the Reference Committee in order to discuss the material there presented.

We had a new member added to our staff of the Illinois State Medical Society since the last meeting. Many of you have met him. He will be a very important cog in the wheels of the operating machinery. I should like to present Mr. Edward A. Uzemack who is Director of Public Relations and Assistant Secretary.

MR. UZEMACK: Thank you Dr. Norbury. I am very privileged to be working with the Illinois State Medical Society. I am very pleased that I can attend this meeting. I am trying to catch up with what is going on in my very first meeting of the Illinois State Medical Society. I hope I will be able to serve you.

THE PRESIDENT: Is there any other new business to be presented to the House at this first meeting?

THE SECRETARY: We would like to have the Chairmen of the Reference Committees come up and get their folders that we have prepared for them. When their names are called, we would like to have the members of each committee stand so they may be recognized by the Chairman.

THE PRESIDENT: If there is no other business, I will entertain a motion for adjournment.

DR. J. MATHER PFEIFFENBERGER, Madison County: I move we adjourn. (Motion seconded by Dr. Caesar Portes, Cook County, and carried).

THE PRESIDENT: The House is adjourned (at 11 A. M. to meet again on Thursday afternoon at 3 P. M.).

# Second Session, May 17, 1956

The second session of the House of Delegates was called to order by the President, Dr. F. Garm Norbury, on Thursday, May 17, 1956, at 3:05 P. M.

THE PRESIDENT: The first order of business is the report of the Credentials Committee, Dr. Charles Allison, Chairman.

DR. ALLISON: The Credential Committee has received 142 signed attendance slips. I move that the attendance slips constitute the voting strength of this meeting. (Motion seconded by Dr. E. S. Hamilton, Kankakee County, and carried).

DR. LEO P. A. SWEENEY: I rise to a point of personal privilege. Mr. Chairman and Members of the House: I would like to direct your attention to the Illinois State Medical Society's constitution and by-laws, page 5, Section 7, entitled "Honorary Members". It states: "Honorary members shall be those physicians of Illinois or other states, territories, island possessions or foreign countries who have risen to prominence in the profession of medicine and who may be elected by a nine-tenths vote of the House of Delegates present at any annual meeting. I would like to direct your attention to some material pertaining to Dr. George F. Lull, Secretary and General Manager of the American Medical Association.

Dr. Lull was born in Scranton, Pa. on March 10, 1887. He received his M. D. at Jefferson Medical College in 1909. Three years later he joined the U. S. Army Medical Corps as First Lieutenant. Over the years he served in all grades, up to and including Major General.

In June, 1943, he was named Deputy Surgeon General of the U. S. Army, serving in that capacity until joining the American Medical Association in 1946 as Secretary and General Manager.

During World War I, Dr. Lull served as commander of the Base Hospital at Camp Beauregard, La. and as Commander of Base Hospital No. 35 in the A. E. F. After the war he served as an instructor in the Army School and as Director of the Department of Preventive Medicine. Later he organized the First Corps Area Laboratory at Fort Banks, Mass. and went on to serve as Assistant to the Eighth Corps Area Surgeon from 1926 to 1929.

For the next three years, Dr. Lull was Medical Advisor to the Governor General of the Philippines. On his return to the States he was named Chief of the Statistical Division in the Surgeon General's office, which post he held for four years. Then he became Director of the Department of Military Sanitation at the Medical Field Service School, Carlisle Barracks, Pa.

In 1940, he returned to duty in the Office of the Surgeon General as Chief of the Military Personnel Division, which post he held until his appointment as Deputy Surgeon General.

Dr. Lull holds several military decorations for his distinguished sevice, among which is the Purple Heart Medal awarded during World War I and the Distinguished Service Medal for his service in World War II. In 1949, the French Government presented him with the coveted Legion of Honor for his work on behalf of France following World War II. The Cuban Government awarded him the Carlos Finlay Order of Merit in 1951.

Dr. Lull holds a Public Health Degree from the Harvard School of Public Health, the degree of Doctor of Public Health from the University of Pennsylvania, and honorary LL. D. from Jefferson Medical College and an Sc. D. from the Woman's Medical College of Pennsylvania. At the recent meeting of the Medical Society of the State of North Carolina, Dr. Lull was made a life member of that Society.

As you know, Dr. Lull has been an active member of the Illinois State Medical Society for many years and it is the belief of several members of this Society that the abilities and attainments of the General should receive high recognition by this Society. Therefore, I recommend to this House of Delegates that Dr. George F. Lull be made an honorary member of this Illinois State Medical Society.

(DR. B. E. MONTGOMERY, Harrisburg: I would like to move that the recommendation be adopted without reference and that Dr. George F. Lull be made an honorary member of the Illinois State Medical Society. Motion seconded by Dr. Walter Bornemeier, Chicago).

THE PRESIDENT: You have heard the constitution read and you know that requires a nine-tenths vote. (The motion was unanimously carried).

THE PRESIDENT: I am going to change the order a bit because I am informed that a very good friend of the Medical Society, the medical profession, and a good friend personally of many of us here is today celebrating his 53rd birthday, and I think it is only courteous on our part to ask Mr. Bob Kleckner, Science Editor of the Sun-Times, to rise while the House sings "Happy Birthday".

We have had a very nice intercurrence and we will proceed with the business. The next item on the agenda is the roll call by the Secretary.

THE SECRETARY: Mr. Chairman, the attendance slips will constitute the roll call, unless otherwise desired.

THE PRESIDENT: The next order of business is the reading of the minutes of the first session of the House of Delegates. (The Secretary read the minutes).

DR. CHARLES H. PHIFER, Chicago: I move the adoption of the minutes as read. Motion seconded by Dr. W. E. Kittler, Ogle County, and carried).

THE PRESIDENT: The next item on the agenda is the selection of a meeting place for 1959.

THE SECRETARY: The same conditions exist in the larger areas of Illinois outside of Chicago. There are no facilities available in Springfield, Rockford, Peoria or East St. Louis. Here we can have our entire meeting under one roof. In other cities, it would be necessary to have three or four other places. The Council has gone on record as favoring Chicago. We have selected Chicago for the 1957 and 1958 meetings. The matter is before you for the selection of a meeting place for 1959.

DR. J. MATHER PFEIFFENBERGER, Madison County, I move that the meeting place be Chicago for 1959. (Motion seconded by Dr. George E. Kirby, Bureau County, and carried).

THE SECRETARY: I overlooked the fact that we did have two invitations extended, one of them we did not answer in the two weeks required. We received another rather urgent letter to have our 1957 meeting in Miami, and also a request from Honolulu for 1957. I wrote them that our meetings were arranged two years in advance.

DR. J. MATHER PFEIFFENBERGER: I do not think we acted on the roll call. I move that the slips made out at the door constitute the roll call. (Motion seconded by Dr. Charles H. Phifer, and carried).

THE PRESIDENT: The Secretary tells me there is no unfinished business. We will now come to new business. The Secretary has no communications.

DR. E. S. HAMILTON: Is this the time to introduce a new resolution? With your permission may I make a few preliminary remarks?

THE PRESIDENT: We always like to have information from you.

DR. HAMILTON: I am appearing in a dual role as member of the Council and as Chairman of the Examining Board of the Department of Medical Registration and Education. I have been a member of this Board for some 15 years and Chairman for several years. Problems have arisen in past years which have complicated the activities of this Board to a great extent. I do not desire to take time to acquaint you with all of them nor do I feel that I would be able to explain all things that should be explained. Suffice to say, that in the past few years many problems have arisen for licensing people for medical practice in the State of Illinois. The large number of foreign people who have come in has made a very distinct problem and one that has had many facets. I am sure you are aware of this. A rather sympathetic administration at times has further complicated the work of the Examining Board, so it has been very difficult for them to police the medical profession of the State of Illinois to find those who are not licensed and those who want to be licensed. Recently there have been some decisions by the Supreme Court which affect the licensing of osteopaths and chiropractors. I think you are all conversant with them because they have been discussed in this hall before. As a result licensing becomes more and more difficult, and it is becoming more and more difficult to keep track of what is going on by licensed and unlicensed doctors in the State of Illinois. Complicating this, there is the big problem of securing funds to do this. We have two other members of the Board here. One is Dr. Kenneth H. Schnepp of Sangamon County, and the other is Dr. B. E. Montgomery of Saline County. I think I see in the House Dr. J. J. Moore who has resigned after many years of service on the Board. If you have questions, after the meeting some one of these men will be glad to answer them. The first statement projects the reason for presenting this resolution which I shall now read.

WHEREAS, in its administration and enforcement of The Medical Practice Act, the Medical Examining Committee of the Department of Registration and Education of this State is substantially hampered by the lack of adequate funds; and

WHEREAS, such lack of funds makes it difficult, and in some instances impossible for the Committee to carry out proper investigations of medical schools and hospitals, to conduct effective examinations for licensure, to obtain current and complete information as to instances of unauthorized or illegal practice and to assist local law enforcement officials in the prosecution of violators of the Act; and

WHEREAS, the Medical Examining Committee is of the considered opinion that the annual registration of physicians in Illinois, and the modest revenues which it would produce, would supply the Committee with much valuable information, and materially assist in greatly improved administration;

NOW THEREFORE BE IT RESOLVED, that the Illinois State Medical Society, through its House of Delegates now

meeting in annual session, express its approval and support of the Medical Examining Committee in this regard, and declare its favorable attitude toward legislation requiring the annual registration of all persons licensed under the Medical Practice Act; provided that any such legislation fix the fee for annual registration at a reasonable figure, and provide that the funds received from this source by the Department of Registration and Education be specifically earmarked for the administration of the Medical Practice Act.

THE PRESIDENT: Do you wish this acted upon today without reference?

DR. HAMILTON: I think it should go through regular channels, we have no desire to hurry it.

THE PRESIDENT: This will be referred to Committee "C", reports of Standing Committees, Dr. Whiting, Chairman.

DR. WARREN W. FUREY, Chicago: I have a resolution.

WHEREAS, a bill to establish a National Library of Medicine in Chicago was introduced in Congress yesterday by Representative Timothy Sheehan of Illinois; and

WHEREAS, the need for such a library has been designated as imperative, in the Hoover report, because of the inadequacy of the present armed forces medical library; and

WHEREAS, Chicago, the leading medical center of the nation, is ideally located for such a library; and

WHEREAS, the Medical Center Commission of Illinois, recognizing the value of such a library has taken unanimous action to invite the establishment of such library in the Medical Center of Chicago and has made a grant of land available without cost, for establishment of said library;

THEREFORE BE IT RESOLVED, that the House of Delegates of the Illinois State Medical Society join with others in the furtherance of this project and express its wholehearted support of this activity; and

BE IT FUTHER RESOLVED, that the Secretary furnish a copy of this action to our Congressional delegation, the President of the United States and the Secretary of the Department of Health, Education and Welfare.

This resolution was prepared at the request of the Council of the Illinois State Medical Sociey by the Chairman of the Committee on Constitution and By-Laws, and it is signed by Drs. Warren W. Furey, E. A. Piszczek, Leo P. A. Sweeney, Otto L. Bettag, Harlan English, Jacob E. Reisch, B. E. Montgomery, and Walter Bornemeier.

Mr. Chairman, does this need reference to a Committee?

THE PRESIDENT: If we follow the usual procedure of getting a two-thirds vote it can be adopted.

DR. CHARLES H. PHIFER: I move its adoption. (Motion seconded by Dr. Elmer V. McCarthy, and carried unanimously).

THE PRESIDENT: The motion is carried by more than the two-thirds required.

THE PRESIDENT: The next item of business is the election of Emeritus Members, and of Past Service and Retired Members.

THE SECRETARY: These candidates have all been checked carefully and can qualify legally for these various types of membership. The request for change in membership in each case has come from the local county medical society. The candidates for Emeritus membership are as follows:

Harry W. Ackemann, Talcott Building, Rockford, Winnebago County

Milton J. Babcock, Biggsville, Henderson County

O. Zelesny Baumrucker, 1916 S. Austin Blvd., Cicero, Chicago Medical Society

James E. Dixon, Mt. Vernon, Jefferson-Hamilton County

J. S. Eisenstaedt, 5454 South Shore Drive, Chicago Medical Society

John Clinton Ellis, 5820 Adeline, Oakland Calif., Macon County

Harvey D. Fehrenbacher, Flora, Clay County

Robert E. Johnson, 419 N. Vermilion, Danville, Vermilion County

Robert L. Kane, Herrin, Williamson County

Walter E. Kittler, Rochelle, Ogle County

Elmer L. Mertz, Talcott Building, Rockford, Winnebago County.

Eugene J. O'Neill, 1059 W. Garfield Blvd., Chicago, Chicago Medical Society

John W. Ovitz, Sr., Sycamore, DeKalb County

Maude H. Winnett, 2655 E. 74th Street, Chicago, Chicago Medical Society.

DR. E. S. HAMILTON: I move these people be elected to Emeritus membership. (Motion seconded by Dr. Charles P. Eck, Chicago, and carried. The Chair declared them elected as Emeritus members).

THE SECRETARY: We have one candidate for Past Service Membership, Dr. Joseph M. Ketay, 2404 Gale Ave., El Vista, Peoria.

DR. E. S. HAMILTON: I move he be elected. (Motion seconded by Drs. Charles P. Eck and Charles H. Phifer, and carried. The Chair declared Dr. Ketay elected as a Past Service Member).

THE SECRETARY: We have three candidates for Retired Membership:

Richard F. Greening, Box 445, R. R. 6, Tucson, Ariz., Chicago Medical Society

Ernest M. Pistor, Dundee, Kane County

John Smuk, 634 N. St. Louis Avenue, Chicago, Chicago Medical Society

DR. W. W. FULLERTON, Randolph County: I move the election of these three men to Retired Membership. (Motion seconded by Dr. Charles H. Phifer, Cook County, and carried. The Chair declared them elected to Retired Membership).

DR. W. E. KITTLER, Ogle County: What is the difference between Emeritus and Retired?

THE SECRETARY: An Emeritus member is an active member, who can remain in practice and still be a member of the House of Delegates and participate in the deliberations. A retired member is one who on account of any infirmity is compelled to retire. An Emeritus Member is a man who has attained the age of 70 and has been a member for 25 years; it does not say in the constitution, consecutive years.

DR. JAMES H. HUTTON, Chicago: I have a resolution.

WHEREAS, at the 1955 Annual Meeting of the Illinois State Medical Society the House of Delegates passed a resolution requesting the Governor of the State of Illinois to appoint a commission composed of practicing physicians, nurses, hospital administrators and educators to study the problems of the nurses' training schools in Illinois; and

WHEREAS, The Council of the Illinois State Medical Society after careful consideration passed the following resolution:

> "That the Council of the Illinois State Medical Society request the Governor to appoint a separate commission composed of practicing physicians, nurses, hospital administrators and educators to conduct a study of the critical shortage of nurses' training schools and teaching facilities for nurses within the state",

and

WHEREAS, a copy of this resolution was sent to the Honorable William G. Stratton, Governor of Illinois, under date of August 15, 1955, and another letter of similar character on March 13, 1956, and

WHEREAS, the American Legion, Department of Illinois has passed a similar resolution, and has made similar requests on two occasions to the Governor; and

WHEREAS, the Illinois Agricultural Association has become interested and concerned over the critical sit-

uation created by the closing of a large number of nurses' training schools in Illinois in a relatively short time; and

WHEREAS, information recently obtained seems to indicate that the most feasible approach to this problem would be through the creation of a Legislative Commission to conduct a thorough study of the current situation in Illinois in relation to the training of nurses;

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Illinois State Medical Society, at this 1956 Annual Session, declare its support of legislation for the creation of a Legislative Commission, composed of members of the Illinois General Assembly, and of members to be appointed by the Governor from nominations submitted to him by representative statewide groups having interest in and familiarity with the problems of nursing service and education in this state.

In Reference Committee "E" to which this resolution came there was a lot of discussion. It has been rewritten and is presented now instead of as part of the report. The Committee recommends that the House adopt the resolution and I so move. (Motion seconded by Drs. E. S. Hamilton, and Charles H. Phifer, and carried).

THE PRESIDENT: The Chair recognizes Dr. Tom Kirkwood, Lawrence County.

DR. KIRKWOOD: I want to speak to you for a moment in respect to Volume II of the History of the Practice of Medicine in the State of Illinois. I doubt whether any of you realize the amount of work put into this by Dr. Hutton and his Committee and by the Editor, the late Dr. D. J. Davis. There is a lot of interesting material in this book. We would like to have everybody subscribe for this volume, and to go back to your county societies and ask them to purchase copies for the medical school and college libraries in their vicinity and for the high schools in the county. Other people put out a lot of information about the so-called practice of medicine and I think it will be a good thing to have the students read these books, and therefore they should be put in the medical school, college and high school libraries.

THE PRESIDENT: We have come to probably the most important phase of the second session of the House, the reports of Reference Committees. The first one will be from the Committee on Reports of Officers, Dr. Armand J. Mauzey, Chairman.

*Report of the Reference Committee on Reports of Officers*

*Report of the President*: The Committee on Reports of Officers unanimously recommends that the report of the President be adopted. This Committee compliments Dr. Norbury for the modesty of his report. He has been our Society's Number One public relations representative this past year as evidenced by his attendance at numerous meetings and conferences throughout Illinois and the nation. Our President has emphasized the help he received from the component societies, committees and individuals. His humbleness does not minimize the magnitude of his own contributions to the Illinois State Medical Society.

(DR. MAUZEY: I move the adoption of this portion of the report. Motion seconded by Dr. W. E. Kittler, and carried).

*Report of the President-Elect*: The Committee on Reports of Officers unanimously recommends that the report of the President-Elect be adopted. This report indicates that Dr. Stone has a firm grasp of the President's duties and that he actually has been fulfilling many of them during this past year. He, too, has practiced good "public relations" and has shown that he possesses the capabilities and energy to assure our Society of continued success under his leadership.

(DR. MAUZEY: I move you the adoption of this portion of the report. Motion seconded by Dr. W. W. Fullerton, Sparta, and carried).

*Report of the Secretary-Treasurer*: The Committee on the Reports of Officers unanimously recommends that the report of the Secretary-Treasurer be adopted.

The Committee urges that the report be studied in detail by each delegate because it is a concise review of the activities of the State Society for the year 1955-1956.

The tremendous amount of work which is handled by Dr. Camp cannot be over-emphasized. The close relationship between the Monmouth and the Chicago offices is well established. The efficiency of these offices would not be possible if it were not for the ability and sincerity of our Secretary-Treasurer and his able staff.

(DR. MAUZEY: I move you the adoption of this portion of the report. Motion seconded by Dr. W. E. Kittler, and carried).

The committee on the Reports of Officers has considered the following resolution:

WHEREAS, the Council of the Illinois State Medical Society has felt that the annual meeting of the Society is an important event which should attract a large registration, and

WHEREAS, the Council feels that in spite of every medium possible having been used to attract a larger registration, attendance has gradually decreased.

THEREFORE BE IT RESOLVED, that the House of Delegates here assembled at the 1956 annual meeting direct and request the Council to explore the possibility of changing the time of the annual meeting to the fall of the year instead of the spring.

It is the unanimous opinion of the Committee on Reports of Officers that this resolution be adopted.

The Committee respectfully suggests that the Council consider all factors which would influence registration at the annual meeting. This would include not only the date of the meeting but numerous other factors which tend to encourage increased attendance.

(DR. MAUZEY: I move the adoption of this portion of the report. Motion seconded by Dr. E. V. McCarthy, and carried).

(DR. MAUZEY: I thank the House of Delegates and the Members of the Committee. The report is signed by Charles P. Eck, Anders J. Weigen, Russell M. Jensen, Robert E. Dunlevy, and Armand J. Mauzey, Chairman. I move the adoption of the report as a whole. Motion seconded by Dr. E. V. McCarthy, Chicago, and carried).

THE PRESIDENT: The next report is from the Reference Committee on Reports of Councilors, Dr. Percy E. Hopkins, Chairman.

*Reference Committee on Reports of Councilors*

The Committee appointed to receive and report on the reports of (1) Chairman of the Council, (2) the Councilors of the eleven Councilor Districts, and (3) the Councilor-at-Large, begs to submit the following report:

The Chairman of the Council as well as several Councilors appeared before this Reference Committee and offered explanatory and supplementary statements which were of much value to the Committee. The Committee is grateful to these gentlemen.

The report of the Chairman of the Council has been considered, together with his report as the Councilor of the Second District, which he represents in the Council of the Illinois State Medical Society. His reports are brief, provide no controversial matter, and refer to the vast amount of work performed by the Council and various committees, the value of the Executive Committee of the Council in expediting the work of the Council is emphasized, and the Reference Committee is in accord with the laudatory remarks pertaining to it.

Attention is also called to the shortage of nurses existing in this District, and the cooperation of the Illinois Agricultural Association in calling attention to this situation in an effort to alleviate it. The short-

age of nurses, and the continuing closing of nurses' training schools, present a serious problem not only in this district, but to the entire State of Illinois. This problem is being considered by another Committee, and will not be discussed further here, other than to deplore the present situation and hope that the entire population will become alerted to and help solve it.

Contained in, as well as omitted from this report, are references to the tremendous amount of work and responsibility imposed on the Chairman of the Council. The Reference Committee feels that modesty prevents the Chairman of the Council from emphasizing this aspect of his position and, therefore, recommends to the House of Delegates that he be commended for his faithful, impartial and valuable contribution to the Illinois State Medical Society as Councilor and Chairman of the Council.

(DR. HOPKINS: I move the adoption of this portion of the report. Motion seconded by Dr. E. S. Hamilton, and carried).

The report of the Councilor of the 1st District demonstrates that a Councilor may be very helpful in ironing out grievances and misunderstandings in his district, and the Committee calls attention of the House of Delegates to this fact. Such efforts provide valuable contribution to public relations.

(DR. HOPKINS: I move the adoption of this portion of the report. Motion seconded by Dr. E. V. McCarthy, and carried).

Report of the Councilors of the 3rd District. This report pertains to activities in the area of the Chicago Medical Society with its 15 branch groups and 23 specialty societies. The Illinois State Medical Society may note with pride some of the activities of this component society, such as the functioning of a rapidly expanding Doctors' Emergency Service, able to answer about 95% of the calls; the continuation of the long existing well-seasoned Grievance Committee; an active Ethical Relations Committee, and the continued provision of an Annual Clinical Conference. There were 6,413 registrants at the 4-day Clinical Conference this year, and it has now become one of the outstanding intensive postgraduate conferences in the country.

The Tuberculosis Control Committee has been in existence for eleven years in this area, and has been productive of considerable progress in the control of tuberculosis. This Committee has consistently urged hospitals to take admission x-ray films as a means of controlling this disease. The Public Relations Committee has actively cooperated with other organizations in the interest of public relations and will combine with other organizations on behalf of the Chicago Medical Society in putting on a Health Fair in Chicago this fall.

The Woman's Auxiliary has cooperated with the Chicago Medical Society and has been active in sponsoring Nursing Scholarships, and in donating to the Benevolence Fund and the American Medical Education Foundation, as well as conducting other activities.

The Veterans' Service Committee has turned its attention to an inquiry having to do with the possible evasion of military service by certain doctors, including graduates of foreign medical schools.

Included in the report of the Councilors of this district is reference to the continuing growth and progress of the Blue Shield Plan of the Illinois Medical Service. During 1955 a total of nearly $10,000,000 was paid to physicians for services rendered. Expansion of benefits continues with the offering of new certificates and just recently a non-group enrollment was made available for a limited time in conjunction with Blue Cross. At no time since the inception of the Blue Shield Plan have the premiums been raised, but on one occasion were actually reduced. The Blue Cross Plan of Chicago, with a membership of about 2½ million members, paid out about 44½ million dollars for hospital care in 1955. While no mention is made in the reports of other Councilors of the existence of other Blue Shield Plans, the Committee is aware of the existence of three other Blue Shield Plans in the state and their continued growth. The existence and successful growth of these plans provide part of the answer to socialized medicine.

The report of the Councilors of the District portrays the activities of a large component medical society with its many activities—they should be commended.

(DR. HOPKINS: I move the adoption of this portion of the report. Motion seconded by Dr. E. H. Weld, Winnebago County, and carried).

For the sake of brevity and in order to avoid too much repetition, the reports of the Councilors of the other Districts will be considered in combined portions of this report.

As previously referred to in the report of the Councilor of the 2nd District, reference is made in the reports of several Councilors to the shortage of nurses in their districts, and the progressive abandonment of training schools for nurses. The Reference Committee deplores the existence of this situation, but is aware of the effort to take remedial measures by the Council of the Illinois State Medical Society, as well as the fact that the matter has been presented to another Reference Committee which will be much better qualified to discuss the subject intelligently.

(DR. HOPKINS: I move the adoption of this portion of the report. Motion seconded by Dr. E. V. McCarthy, and carried).

The reports of the Councilors of the 9th and 10th Districts refer to the problems arising in connection with the care of I. P. A. C. recipients, as well as controversial matters involving the provision of medical care for the U. M. W. A.

The Reference Committee is aware of the sincere efforts on behalf of the Chairman of the State Advisory Committees to these organizations, but inasmuch as reports on these subjects are to be considered in detail elsewhere, this Committee makes no recommendation in this connection.

(DR. HOPKINS: I move the adoption of this portion of the report. Motion seconded by Dr. E. H. Weld, and carried).

The Reference Committee notes with commendation the activities of the Councilor of the 5th District, such as participation in the Illinois State Fair and the Secretaries Conference. This Councilor, as well as the Councilors of the 6th and 7th Districts make reference to some problems arising in conjunction with the postgraduate conferences held throughout their districts. It is the considered opinions of these Councilors that the postgraduate conferences held in areas other than the metropolitan areas with the larger hopitals are much better received and attended than in the areas with the large hospitals. Required attendance at hospital meetings may be one of the reasons for this fact. The caliber of the programs at all postgraduate meetings has been excellent. The suggestion has been made by these Councilors that an effort be made to permit credit by the Illinois Academy of General Practice, and the hospital staff organizations, to the men who attend these postgraduate meetings. Perhaps hospital staff meetings, or clinical conferences, could be combined with postgraduate meetings. The Committee is of the opinion that these suggestions have merit, and should be called to the attention of the Postgraduate Education Committee for exploration and the Reference Committee so recommends.

(DR. HOPKINS: I move the adoption of this portion of the report. Motion seconded by Dr. E. V. McCarthy, and carried).

The Councilor of the 8th District calls attention to the continued growth of the Health Improvement Association membership with an improvement in the

financial aspect. One of the assets of the Health Improvement Association is to provide a media whereby members may enroll as groups in Blue Cross and Blue Shield. Illinois Medical Service has been an active participant in this movement.

This Councilor sagely remarks to the effect that the Public Assistance roll continues at about the same level with the federal and state financing of our citizens, and no one seeming to know the answer why this is true, causes the Committee to observe that perhaps many people who are able, fail to assume a moral obligation to care for their relatives, as well as the evidence of too much encouragement to ask for help from governmental sources. How to change this philosopy is far beyond the imagination of this Committee.

(DR. HOPKINS: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

The Reference Committee wishes to pay tribute to the Councilors for their donation of time, thought and effort in carrying on the work of the Illinois State Medical Society. These positions require considerable sacrifice in the performance of duty, and the Committee recommends that the Concilors be commended for their efforts on behalf of the Society.

(DR. HOPKINS: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

This report has been signed by Allison Burdick, Edward Helfers, William Scanlan, and Eugene Johnson, and Percy E. Hopkins, Chairman. I am very grateful to the Committee for their help. I move the adoption of the report as a whole. (Motion seconded by Dr. Harlan English, Vermilion County, and carried.

THE PRESIDENT: The report is adopted with the thanks of the Chair to Dr. Hopkins and his Committee.

The next report is from the Reference Committee on Reports of Standing Committees, Dr. William Whiting, Chairman.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

I would like to take this opportunity to thank all of the members of my Committee for the excellent cooperation which they have given to assure the accomplishment of our deliberations. I would most especially like to thank all of those persons who attended the open meetings of the Committee, took an active part in the discussion relative to the various aspects of the Committee business and made their opinions and information available to us. May I also point out that the effectiveness of the Reference Committee's work is dependent in large part upon the attendance and participation of those physicians who are interested in the problems confronted by the Committee and I would like to emphasize that the conclusions of the Committee and the opinions expressed by the Committee are frequently determined by information received in open discussion and to point out that the final results are determined by the quality and clarity provided by such discussion.

The Committee considered in detail the reports as published in the Handbook, pages 52 through 64 and during the report will make specific references to certain material as printed there and suggests that you refer to this during the reading of the report. In addition, we have considered resolutions referred to the Committee by the House of Delegates.

Your Reference Committee considered the report of the *Committee on Medical Service and Public Relations* as published in the Handbook pages 52 through 56, in detail and wish to take this opportunity to commend the Committee for the excellence of the work accomplished during the past year and for the comprehensiveness of the report as published in the Handbook. We wish to take special note of the employment of Mr. Edward A. Uzemack as Director of Public Relations and Assistant Secretary of the Illinois State Medical Society beginning April 1, 1956 and feel confident that Public Relations affairs of the State Society will be expedited through his employment. The Committee understands that the portion of the report dealing with legislative matters is the definitive report of the Associate Counsel, Mr. Walter Oblinger, and wishes to commend him and the Committee for the work he has done. We also, however, wish to point out that more effective participation by physicians throughout the State of Illinois in legislative matters will be necessary in order to accomplish the aims of organized medicine and wish to take this opportunity to encourage every physician to take part to the extent of his time and ability.

Your Reference Committee wishes to compliment the Committee on Medical Service and Public Relations on the appropriateness of the selection of Dr. Elbridge W. Telford of DeKalb as the Illinois General Practitioner of the year and for the excellence with which this matter was carried out.

The Committee considered the supplementary report as presented in the House of Delegates on Tuesday, May 15, 1956, and appreciated the information provided therein.

Your Reference Committee was assured in open discussion that a Public Relations meeting will be undertaken after the Annual Meeting in conformance with the recommendations of the Committee on Medical Service and Public Relations. We wish to reemphasize the importance of Public Relations as an aspect of Medical Service in this State, to compliment the Committee on what has been accomplished in the past and to encourage all physicians to participate to their full capacities in programs to come in the future.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. W. H. Walton, and carried).

Your reference Committee was cognizant of the brevity of the report of the *Committee on Archives* as published in the Handbook. pages 56 and 57. In discussion with the Chairman of the Committee it was suggested that it might be practical to combine the functions of the Committee on Archives and the Committee on Medical History and we recommend to the House of Delegates that this matter be considered in the future.

With specific reference to the activities of the Committee from the standpoint of gathering information concerning individual physicians in the state, it was suggested in open discussion and it is recommended by the Reference Committee that a special form be prepared including a letter of condolence to the widows of the deceased physicians and a request for information relative to this physician's activities throughout his lifetime of practice and that this be forwarded to the John Crerar Library as depository. We recommend that such a letter be sent out by the office of the Secretary of the Illinois State Medical Society when notification of the death is received and that copies of the letter be forwarded to the component society secretary, to the Councilor of the District in which the component society is located and to the Committee on Archives and/or Medical History for information in order to assure adequate evaluation of any materials received.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. W. H. Walton, and carried.)

Your Reference Committee considered the report of the *Medico-Legal Committee* as published in the Handbook on page 58. There was significant discussion of numerous matters related to medico-legal

liability in open session. We would like to emphasize this aspect of our professional responsibilities and to re-emphasize the information presented in the last paragraph of the report.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. W. H. Walton, and carried).

THE PRESIDENT: I am sure, knowing our incoming President's knowledge and interest, that during the next year we will have a better understanding of this.)

This Reference Committee was impressed by the report of the *Committee on Medical Benevolence* as published in the Handbook on pages 59 and 60, and compliment them on the excellence of the work done during the year and the comprehensiveness of this report. The Reference Committee would like to call the attention of the House to the recommendations made by the Committee in the final paragraph on page 59 in the Handbook and would like to re-emphasize the importance of adequate considerations of all of the matters mentioned.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. W. H. Walton, and carried).

This Reference Committee considered in detail the report of the *Committee on Medical Education and Hospitals* as published in the Handbook on pages 60 through 62. We note that the informational material presented deals primarily with the National situation in medical education and hospitals but we realize that this national situation has an important bearing on all state activities. Your Committee took special note of the discussion relative to the distribution of medical costs and its relations to criticism of physicians as presented in the first paragraph of the report. Realizing that such informational material and action upon it constitutes one of the most important aspects of public relations of the medical profession we feel that much further emphasis must be placed upon this aspect of professional public relations. Your Reference Committee approves of this report and wishes to commend the Committee for what it has done in the past year.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. W. H. Walton, and carried.)

The Committee considered the report of the *Committee on Medical Testimony* as published in the Handbook on pages 62 and 63, and heard numerous individuals in open session relative to different facets of this problem. We took special note of paragraph 2 in the report and agreed with the recommendations presented there and recommend further consideration and implementation of these suggestions, noting that this has been done in other societies.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. W. H. Walton, and carried).

Your Committee noted with interest all of the points discussed in the report of the *Grievance Committee* as published in the Handbook on pages 63 and 64. In open discussion many matters with specific reference to Grievance Committee functions were discussed. We made special note of the information relative to the booklet published by the American Medical Association. We wish to recommend to the House the encouragement of the activation of Grievance Committees in all component societies or groups of societies. Your Committee took special note of the suggestion in the report that changes to the by-law be considered to provide for appeal to the State Grievance Committee from the decision of a component society and would like to point out that such action has been taken.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, and carried).

Your Reference Committee considered in detail and prolonged consultation the resolutions presented to it for action.

Recognizing that there are many facets of the complicated problem of accreditation of our hospitals which need to be worked out over the years, we recommend that the following resolution received from the Madison County Medical Society be adopted as amended by the Reference Committee:

*Whereas,* the American Medical Association is a proven successful accreditation body in many fields, and

*Whereas,* the Joint Commission on Hospital Accreditation has been widely criticized by large segments of the membership of the American Medical Association;

*Therefore be it resolved,* that this House of Delegates request that the delegates to the American Medical Association Convention in June, 1956 do all that is possible to carry out a program that will lead to dissolution of the Joint Commission and the formation of a Hospital Accreditation Committee of the American Medical Association.

(DR. WHITING: I move the adoption of this portion of report. Motion seconded by Dr. Caesar Portes).

DR. WALTER BORNEMEIER, Cook County: Is that the Madison County resolution or the substitute?

DR. WHITING: It is the substitute.

DR. BORNEMEIER: Please read the Madison County resolution.

(Dr. Whiting reads resolution as it appears in the minutes of the First Session of the House).

DR. WHITING: Would you like me to read the revised resolution?

DR. BORNEMEIER: Yes.

(Dr. Whiting reads the revised resolution).

DR. A. J. BRISLEN, Chicago: As a member of the Committee and to help clarify the point raised by Dr. Bornemeier, the Joint Commission is not truly representative and we said, "has been widely criticized..." As a member of the Committee, under "therefore be it resolved," it states, "that this House of Delegates requests that the Delegates to the American Medical Association Convention in June, 1956, formulate and carry out a program at the June meeting designed to effect the dissolution of the Joint Commission and the formation of a Hospital Accreditation Committee of the American Medical Association to take its place", which means that a program must be carried out in four weeks. We felt it was impossible to formulate and motivate it in four weeks, and we suggested that "our delegates. . .do all that is possible to carry out a program that will lead to dissolution of the Joint Commission and the formation of a Hospital Accreditation Committee of the American Medical Association".

DR. BORNEMEIER: I do not believe you can form a hospital accreditation committee of the A. M. A. and make it binding at all unless the Hospital Association would invite the A. M. A. to form such a committee. After all, this is advisory. True, they accepted the American College of Surgeons for years and they got used to having them. Now in this joint affair the majority of the people are doctors. I think there are reasons for criticism but I think they can be worked out.

DR. JOHN WALL, Chicago: The Joint Accreditation Committee has representatives from the American and Catholic Hospital Associations. No matter what we say, it will continue.

THE PRESIDENT: You are aware that the amended resolution as presented by the Committee has been proposed for adoption. What is your pleasure? (Motion for adoption carried).

(Dr. Whiting continues with the report)

Your Reference Committee had the opportunity in extended discussion with numerous interested individ-

uals to evaluate the problem of qualifications for medical practice and licensure in the State of Illinois. Realizing that there are many aspects of this problem which must be approached with great care and circumspection we considered the following resolutions in relationship to the information which we received and on that basis took the action which we recommend.

The resolution presented by the Randolph County Medical Society as published in the Handbook on page 143 is recommended for adoption as amended by your Reference Committee.

WHEREAS, at the present time there are many individuals practicing their vocation in the State of Illinois without license, and

WHEREAS, convictions of said individuals for practicing without license are extremely difficult to obtain, and

WHEREAS, even if conviction is obtained the punishment is minimal,

THEREFORE BE IT RESOLVED, that the members of the Illinois State Medical Society protest this laxness in law enforcement and recommend to the legislature of the State of Illinois such modification to the present law so that it would be easier to obtain convictions for practicing without a license and if such conviction is obtained that the punishment be more realistic.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. W. H. Walton).

DR. E. S. HAMILTON: I would like to hear that again. Does it mention practicing medicine anywhere?

(Dr. Whiting reads the resolution)

DR. HAMILTON: Does that include pharmacists and others?

(Dr. Whiting and Dr. Brislen had a small conference)

DR. WHITING: Dr. Hamilton, I did not have the full wording of the first paragraph. (Reads) Does that suit?

DR. HAMILTON: No.

DR. ROBERT E. HEERENS, Winnebago Co.: Perhaps if you would add "convictions under the Medical Practice Act," it would include all types of practitioners.

DR. FRANK FOWLER, Chicago: I do not think it is lack of ease for conviction, it is the facilities for conviction. I would like to move that this be referred back to the Committee to bring in further clarification of the resolution tomorrow.

DR. G. HENRY MUNDT, Chicago: That word "realistic" is badgered around by everybody.

DR. BRISLEN: The determination of punishment is not part of our work. We cannot determine the punishment.

DR. J. ERNEST BREED, Chicago: I second Dr. Fowler's motion.

THE PRESIDENT: From parliamentary standpoint this last motion takes precedence over the motion for adoption of the resolution. Are you ready for the question? (Motion made by Dr. Fowler is carried). The resolution is referred back to the Committee.

DR. WHITING: I would like to request permission to defer the remainder of the report until tomorrow.

THE PRESIDENT: Permission granted. That means that those portions not presented today will come up tomorrow and then action will be taken on the report as a whole. I want to thank you Dr. Whiting and your Committee for the amount of time and work you put in on the portions of the report which the House has already accepted.

The next report will be from the Reference Committee on Council Committees "A", Dr. Warren W. Furey, Chairman.

*Report of Reference Committee on Reports of Council Committees "A"*

The Reference Committee had a most interesting and enlightening session, attended by several Councilors, Committee Chairmen and members, and several Illinois delegates to the House of Delegates of the American Medical Association. We are grateful to all who attended and appreciative of their participation in the deliberations. Fortunately for the Committee the material presented was, for the main part, non-controversial, hence our conclusions were reached without difficulty.

Your Chairman temporarily disqualified himself on two matters: (1) The report of the delegates to the A. M. A., and (2) the resolution concerning alternate delegates to the A. M. A., pages 142-143 of the Handbook, because he had signed both the report and the resolution. Dr. Wright Adams, a member of the Reference Committee, was elected temporary chairman to consider and to present this material.

Mr. President, I would like to have Dr. Adams present that portion of the report.

(Dr. Adams reading)

Your Reference Committee has considered the report of the delegates to the A. M. A. We feel that the delegation is to be commended for its faithful and vigorous work on behalf of American medicine and our State Society. As a small token of the appreciation we felt for their great work I should like to read their names:

Walter C. Bornemeier — J. Mather Pfeiffenberger
Everett P. Coleman — Charles H. Phifer
Harlan English — H. Kenneth Scatliff
Warren W. Furey — C. Paul White
Burtis E. Montgomery — Percy E. Hopkins, Chairman

The Handbook contains an excellent report of the major activities of the House of Delegates of the A. M. A. during the past year. Your Reference Committee wishes to emphasize the fact that the position of the A. M. A. with respect to osteopathy is now clear. Osteopathy is a cult. The A. M. A. will be happy to consider further relations when osteopathy abandons the so-called osteopathic concept.

The A. M. A. took a moderate but firm and clear position with respect to the expansion of social security benefits.

The House took a clear position with respect to the controversy between general practitioners and specialists. In essence, this position was that general practitioners should not lose any of the customary privilege of physicians because they are generalists.

The House of Delegates of the A. M. A. adopted a resolution congratulating the physicians of Iowa for their efforts in supporting the position that the practice of medicine is the right of the individual. Your Reference Committee thinks that this House should commend our delegates for supporting this resolution and should add its own commendation to the physicians of Iowa.

Your Reference Committee has picked a few points from this excellent report for emphasis. We strongly recommend that every member of this House read the report fully and carefully.

Illinois is in a position of leadership in American medicine. This leadership is largely the result of the activities of our delegates. They are to be commended.

(DR. ADAMS: I move the adoption of this portion of the report. Motion seconded by Dr. E. S. Hamilton, and carried).

This Reference Committee also considered the resolution which begins on page 142 of the Handbook. Because it concerns the delegates to the A. M. A., our Chairman, Dr. Furey, has asked that I report on it as well. The resolution as printed in the Handbook does not indicate signatures. The Reference Committee was assured that it was signed by several delegates to the A. M. A.

The resolution provides that this House recommend to the Council that at least half of the alternate delegates to the A. M. A. be requested to attend each meeting of that House of Delegates and that our Society

pay their expenses.

Your Reference Committee feels that the advantages of their attendance for this Society are so great that all alternate delegates should be urged to attend and that their expenses should be paid.

We, therefore, recommend that the implementary clauses of the resolution be changed to read as follows:

Resolved, that alternate delegates to the American Medical Association from the Illinois State Medical Society be requested to attend each meeting of the House of Delegates of the American Medical Association, and be it further

Resolved, that the House of Delegates of the Illinois State Medical Society hereby recommends to the Council of the Illinois State Medical Society that each alternate delegate be reimbursed at the same rate used in calculating allowances for the delegates.

We recommend the adoption of the resolution in this amended form.

(DR. ADAMS: I move the adoption of this portion of the report. Motion seconded by Dr. W. H Walton, and carried).

(Dr. Furey then presents the remainder of the report)

1. Discussion of the reports of the *Editorial Board and Journal Committee,* pages 64 and 65, of the *Editors,* pages 112 and 113 of the Handbook was carried on jointly because both reports concerned rather identical subject material.

It was noted that the quality and content of the Journal has shown marked improvement over the past few years, due largely perhaps to the increased interest and activity of the Editors, the Editorial Board and the Journal Committee. Change in format, diversification of material and more careful screening and review of papers to be published have contributed materially to the increasing value of the Journal.

Dr. Hutton, Chairman of the Editorial Board, indicated that state journals generally are confronted with the problem of presenting journal contents of interest to the greatest number of members, both specialists and general practitioners. It was suggested that one Journal shortcoming was apparent in the sparsity of editorial reports of Council and committee activities; such reports would be of real interest to the medical profession in Illinois, and should be encouraged.

A further suggestion was made that the Journal Committee, Editorial Board and probably the Editors should meet at regular intervals, at least quarterly, in order to facilitate clearance of Journal material. Incidentally, attention was called to the sacrifices made by Dr. Camp in attendance at these meetings, he has been most faithful.

The Reference Committee concurs in the suggestions presented and recommends commendation of the members of the Editorial Board, the Journal Committee, the Editors and the members of the staff for a job well done, and we join with them in welcoming our new Public Relations Director, Mr. Edward A. Uzemack, to the official body of the Society.

(DR. FUREY: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. Charles H. Phifer, and carried).

2. *The Report of the Advisory Committee to the Illinois Public Aid Commission,* pages 71-75, represents an excellent and factual recounting of the activities of this fine committee over the past year. Eight regular meetings of the Committee and three Sub-committee meetings on Radiology and Ophthalmology were held. Although the problems have been many the Committee has chosen to select and elaborate upon three particular problems:

1. Increasing and prolonged hospitalization.
2. Excessive prescribing and dispensing of drugs, particularly the new and expensive drugs.
3. Excessive and unnecessary medical care, including the routine use of many diagnostic procedures which are not consistent with the diagnosis given.

You are urged to study the discussion of these points in the printed report of the Committee, it is well worth while.

The Committee is to be highly commended for its desire to present an outstanding medical care program to the recipients of assistance, at the same time maintaining "the rights and freedom of the profession and the practice of medicine in Illinois." The work of this Committee has not been easy, the results, however, have been outstanding. May we urge their continued effort and your support and cooperation.

A sad note in the report calls attention to the passing of Dr. Julius H. Hess of Chicago, a valued member this Committee since its inception.

(DR. FUREY: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. Harlan English, and carried).

3. *The resolution concerning the Old Age Assistance Program,* pages 141 and 142, presented by Dr. D. M. Roberts, on behalf of the Illinois Academy of General Practice, was discussed by Dr. B. E. Montgomery, Chairman of the Advisory Committee to the Illinois Public Aid Commission, and Miss Leslie Freeman of the Commission. It was pointed out that the problem considered in the resolution came about because of a misunderstanding of procedure. The limitation of hospital visits to ten, in any one acute illness, is not, as indicated, arbitrary and absolutely fixed. Acutely ill patients may have as many visits as necessary; however, in order to prevent abuse of the privilege, the physician must file information explaining the need and urgency of such extra visits with the local welfare agency which in turn will refer the request to the local advisory committee for action. Information made available to the Reference Committee indicated that this procedure has been common practice over a long period of time, hence the intent of the resolution is being covered and furtherance of it is not necessary.

Your Reference Committee, therefore, recommends disapproval of the resolution.

(DR. FUREY: Mr. President, I move the adoption of this section of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

4. *Advisory Committee to the Illinois Occupational Therapy Association,* page 87. is a progress report of the Committee. The Committee is serving a very important cause and is to be commended for the judicious manner in which it has functioned.

(DR. FUREY: I move the adoption of this portion of the report. Motion seconded by Dr. Charles H. Phifer, and carried).

5. *Advisory Committee to Veterans' Administration* is a statistical report of the work load of the Veterans' Administration for the year 1955. The work load while not large does indicate that some consideration is being given to the care of veterans by participating physicians. The report commends the cooperation of members of the Illinois State Medical Society and the high standard of medical care provided veterans in this area. This Committee is deserving of high praise for its continuous outstanding service.

(DR. FUREY: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. E. V. McCarthy, and carried).

DR. FUREY: The report is signed by Drs. Wright Adams, C. D. Swickard, J. P. FitzGibbons, David B. Freeman, M. D. Murfin, and Warren W. Furey, Chairman. I move the adoption of the report as a whole. (Motion seconded by Dr. E. V. McCarthy, Cook County, and carried).

THE PRESIDENT: I will ask Dr. Sweeney to bring Dr. George Lull to the rostrum. (The House stands). Dr Lull, an active member of the Illinois State Medical Society, has been elected this afternoon an Honorary Member as well. Dr. Camp tells me this is the first time in 25 years that this has been done.

Dr. Lull, I do not know whether you were informed about this before, but this is the official information.

DR. LULL: Dr. Norbury and gentlemen: I accept this honor very humbly. I would have been earlier but the man you sent for me had difficulty because he could not locate the right corner. This is a very great honor and I thank you deeply from the bottom of my heart. I appreciate it and I hope I can live up to it.

THE PRESIDENT: While Dr. Lull has been made an Honorary Member we still want him to be an active member as well.

The Chair is of the opinion that we had better not go on with this meeting. The Secretary has some announcements before adjournment.

THE SECRETARY: There are some things which should be brought to your attention. One is the plastic binding on the Handbook and official program. The other is the seating arrangement at tables for the Delegates. Do you approve of these two things? (Applause) I think from the response you want them continued.

DR. HUTTON: I would like to have slips for purchase of the Second Volume of the History of Medicine in Illinois signed up.

THE PRESIDENT: Unless there is opposition the Chair will adjourn this meeting until 8:30 tomorrow morning.

The House adjourned at 4:50 P. M.

# Third Session May 18, 1956

The third session of the House of Delegates was called to order by the President, Dr. F. Garm Norbury, on Friday, May 18, 1956, at 8:50 A. M.

THE PRESIDENT: The first order of business is the report of the Credentials Committee, Dr. Charles Allison, Kankakee, Chairman.

DR. ALLISON: The Crendentials Committeee has 110 signed cards this morning which I believe constitutes a quorum. I move you, Mr. President, that this number constitute the voting strength of this session. (Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

THE PRESIDENT: The next item on the agenda is the roll call by the Secretary.

DR. E. S. HAMILTON, Kankakee: I move that we dispense with the roll call and accept the report of the Credentials Committee. (Motion seconded by Dr. C. H. Phifer, Chicago, and carried).

THE PRESIDENT: The next item is the reading and approval of the minutes of the previous session.

DR. E. S. HAMILTON. Kankakee: I move that the reading of the minutes be dispensed with. (Motion seconded by Dr. J. Mather Pfeiffenberger, Alton, and carried).

THE PRESIDENT: We now come to the announcement of AWARDS to Scientific Exhibitors, Dr. Coye C. Mason, Chairman and Director.

### Awards to Scientific Exhibitors

#### Educational Value

Gold Medal - Booth 4.
- Title: "Surgical Complications of Pregnancy"
- Exhibitors: Frederick H. Falls and Miss Charlotte S. Holt
- Institution: University of Illinois College of Medicine

Silver Medal - Booth 14.
- Title: "Better Medical Writing"
- Exhibitors: Lee D. VanAntwerp, Harold Swanberg
- Institution: American Medical Writers' Association, Quincy

Bronze Medals

1. Booth 21
   - Title: "The Doctor, The Vocational Rehabilitation Team and The Vocational Rehabilitation Client"
   - Exhibitors: E. C. Cline
   - Institution: Illinois Division of Vocational Rehabilitation
2. Booth 1
   - Title: "Surgical Treatment of Varicose Veins by Two-Team Technique"
   - Exhibitors: Arkell M. Vaughn, Cornelius M. Annan, John A. Caserta
   - Institution: Department of Surgery, Stritch School of Medicine of Loyola University, Mercy Hospital and Vaughn Medical Group
3. Booth 3
   - Title: "A Better Understanding of Acid-Base Balance"
   - Exhibitor: Harry F. Weisberg
   - Institution: Mt. Sinai Medical Research Foundation and the Chicago Medical School

#### Original Work

Gold Medal - Booth 10
- Title: "Potentially Pathogenic Bacteria Carried in the Respiratory Tracts of Physicians"
- Exhibitor: Jerome J. Landy, Isabelle Havens, Ross S. Benham
- Institution: University of Oklahoma, University of Chicago

Silver Medal - Booth 24.
- Title: "A New Method of Pelvic Fixation"
- Exhibitor: William Johnson
- Institution: The Galesburg Clinic

Bronze Medals

1. Booth 11
   - Title: "Controlled Arrest for Cardiac Surgery with Hypothermia"
   - Exhibitor: Peter V. Moulder, Richard G. Thompson, Robert W. Harrison, William Kiskind, Barry Siegal, Curtis A. Smith, and William E. Adams
   - Institution: University of Chicago, Department of Surgery
2. Booth 2
   - Title: "Alterations in the Central Nervous System Associated with Various Fungus Infections"
   - Exhibitor: Louis D. Boshes
   - Institution: Division of Neurology and Psychiatry, Department of Medicine and Microbiology, Michael Reese Hospital and Department of Neurology and Psychiatry, Northwestern University Medical School.
3. Booth 16
   - Title: "Palliation of Esophageal Obstruction Due to Carcinoma with a Permanent Intraluminal Tube".
   - Exhibitors: S. A. Mackler, G. Bard
   - Institution: Cook County Hospital, Department of Thoracic Surgery, Michael Reese Hospital, and Chicago Medical School

DR. MASON: I want to extend my thanks to the members of the Committee, Arkell M. Vaughn, Dwight E. Clark, Leo M. Zimmerman, L. W. Peterson, Harold L. Method, Everett P. Coleman and J. C. Thomas Rogers.

THE PRESIDENT: I did not get to spend as

much time around the scientific exhibits as usual, but I thought we had a fine representation. I think the Committee has done a very fine job in securing these exhibits in addition to the detailed and careful consideration given as regards the awards.

The next item of business is the election of officers, and under that is first, nominations for President-Elect. The Chair will recognize Dr. George E. Kirby, Bureau County.

DR. KIRBY: Mr. Chairman and Members of the House of Delegates: I am very pleased to have the privilege of presenting to you the name of a man who is a member of the Illinois State Medical Society from the Second District which has thus far not been honored with the presidency of this Society, Lester S. Reavley of Sterling, Whiteside County. He has been a member of this House of Delegates for 31 consecutive years and is therefore well known to most of you. For the information of the younger members of the House of Delegates I will give you a very brief rundown on Dr. Reavley.

Dr. Reavley was born in Springfield, Illinois 62 years ago come June 17, 1956. His early education was obtained in Riverton, Illinois. He graduated from the Springfield High School in 1913. Following this he began his pre-medical education at Normal University, Normal, Illinois and concluded it in Valparaiso University, Valparaiso, Indiana. Following this he taught school for four years and then entered Loyola University where he was graduated in 1921. He served an internship in the Washington Park Hospital with Dr. Frank M. Phifer, and in 1922, he entered practice in Sterling where he has continued. He was secretary of the Whiteside County Medical Society for 15 years and is a past president. He has been a member of the Board of Directors of the Sterling National Bank since it was founded in 1934, and at the present time he is Chairman of the Board of Directors of this Bank. With these high professional qualifications and being the civic leader that he is, I feel he is well qualified to fulfill the high functions of the Illinois State Medical Society. Thank you.

DR. W. H. SCHOWENGERDT, Champaign: I second the nomination.

DR. MAURICE M. HOELTGEN, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot of this House for Dr. Reavley as President-Elect. (Motion seconded by Dr. George E. Kirby, and carried. The ballot was cast and the President declared Dr. L. S. Reavley elected as President-Elect.)

THE PRESIDENT: Dr. Kirby, would you be good enough as to bring Dr. Reavley up here so the House can look at him.

DR. REAVLEY: I wish to thank the delegates to the Illinois State Medical Society for this honor. I think I appreciate also some of the responsibilities that go along with it. With your help and the help of our good Secretary, Harold M. Camp, I will do my best to be a credit to this organization. I thank you.

THE PRESIDENT: The Chair will recognize Dr. Norris J. Heckel representing the Chicago Medical Society. Dr. Heckel will make the presentations for the various offices for the Chicago Medical Society. Nominations are in order for First Vice-President.

DR. HECKEL: Mr. Chairman and members of the House: On behalf of the Chicago Medical Society's caucus, I would like to present the name of Dr. Frank Fowler as First Vice-President. I am sure that you will agree with me when I say Dr. Fowler has done a wonderful job as Chairman of the Arrangements Committee. (Nomination seconded by Dr. E. S. Hamilton).

Nominations from the floor were called for but none were offered.

DR. LEO P. A. SWEENEY, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Fowler as First Vice-President. (Motion seconded by Dr. E. S. Hamilton, and carried. The ballot was cast and the President declared Dr. Frank Fowler elected as First Vice-President).

DR. FOWLER: I want to thank the delegates for this high honor.

THE PRESIDENT: The next office is that of Second Vice-President.

DR. EDWARD H. WELD, Winnebago Co.: I would like to place in nomination the name of Dr. Norman L. Sheehe. (Nomination seconded by Dr. W. H. Schowengerdt, Champaign).

Nominations from the floor were called for but none were offered.

DR. J. MATHER PFEIFFENBERGER, Alton: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Norman L. Sheehe as Second Vice-President. (Motion seconded by Dr. E. S. Hamilton, and carried. The ballot was cast and the President declared Dr. Norman L. Sheehe elected as Second Vice-President).

THE PRESIDENT: The next office is that of Secretary-Treasurer.

DR. W. E. KITTLER, Ogle Co.: I take great pleasure and delight in nominating Dr. Harold M. Camp to succeed himself. He has been our Secretary for the last 32 years and I hope to be able to see him elected for the next 25 years. (Nomination seconded by Dr. E. E. Davis, Avon.)

Nominations from the floor were called for but none were made.

DR. E. E. DAVIS: I would like to move that the nominations be closed and the President cast the affirmative ballot for Dr. Harold M. Camp as Secretary-Treasurer. (Motion seconded by Dr. Norman L. Sheehe, and carried. The President cast the ballot and declared Dr. Camp elected as Secretary-Treasurer).

DR. CAMP: Again I want to thank you and to assure you that with the assistance of my very capable staff I will do everything I can to carry on next year.

THE PRESIDENT: The next officers to be elected are Councilors, the following terms expiring, Carl E. Clark, 1st District, Joseph T. O'Neill, 2nd District, and from the 3rd District, E. A. Piszczek and Caesar Portes serving the unexpired term of F. Lee Stone, Edwin S. Hamilton from the 11th District. Nominations are in order for Councilor for the 1st District.

DR. J. C. ELLIS, DeKalb: I would like to nominate Dr. Carl E .Clark to succeed himself. (Nomination seconded by Dr. E. H. Weld).

Nominations from the floor were called for but none were made.

DR. NORMAN L. SHEEHE, Rockford: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Carl E. Clark as Councilor of the First District. (Motion seconded by Dr. Edwin H. Weld, and carried. The ballot was cast and the President declared Dr. Carl E. Clark elected as Councilor of the 1st District).

THE PRESIDENT: Nominations are in order for Councilor of the Second District.

DR. WILLIAM SCANLAN, LaSalle: I wish to nominate Dr. Joseph T. O'Neill to succeed himself. (Nomination seconded by Dr. J. C. Ellis, DeKalb).

Nominations from the floor were called for but none were offered.

DR. A. J. BRISLEN, Chicago: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Joseph T. O'Neill as Councilor of the 2nd District. (Motion seconded by Dr. William Scanlan, and carried. The ballot was cast and the President declared Dr. Joseph T. O'Neill elected as Councilor of the Second District).

THE PRESIDENT: The Chair recognizes Dr. Norris J. Heckel to bring in nominations for Councilors of the Third District.

DR. HECKEL: I would like to place in nomination the names of Edward A. Piszczek and Caesar Portes for Councilors of the Third District. (Nominations seconded by Dr. E. A. Lukaszewski, Chicago).

Nominations from the floor were called for but none were offered.

DR. CHARLES H. PHIFER, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Drs. Edward A. Piszczek and Caesar Portes as Councilors for the Third District. (Motion seconded by Dr. Edwin A. Lukaszewski, and carried. The ballot was cast and the President declared Drs. Edward A. Piszczek and Caesar Portes elected as Councilors for the Third District).

THE PRESIDENT: Nominations are in order for Councilor for the Eleventh District, Dr. E. S. Hamilton's term expiring.

DR. CHARLES ALLISON, Kankakee: I would like to nominate Dr. E. S. Hamilton to succeed himself. (Nomination seconded by Dr. E. V. McCarthy, Chicago).

Nominations from the floor were called for but none were made.

DR. ALLISON: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. E. S. Hamilton as Councilor for the 11th District. (Motion seconded by Dr. J. Mather Pfeiffenberger, and carried. The ballot was cast and the President declared Dr. E. S. Hamilton elected as Councilor for the 11th District).

THE PRESIDENT: The next item on the agenda is the election of delegates to the American Medical Association, to take office on January 1, 1957 and serve for a term of two years. The terms expiring are those of Drs. Percy E. Hopkins, Warren W. Furey, and Charles H. Phifer of Chicago, and C. Paul White, Kewanee, and Burtis E. Montgomery, Harrisburg. The Chair recognizes Dr. Norris J. Heckel to bring in nominations from the Chicago Medical Society.

DR. HECKEL: I would like to place in nomination as delegates to the American Medical Association the names of Drs. Percy E. Hopkins, Warren W. Furey, and Charles H. Phifer. (Nominations seconded by Dr. Frank Fowler, Cook County).

Nominations from the floor were called for but none were offered.

DR. H. K. SCATLIFF, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Drs. Hopkins, Furey and Phifer as delegates to the American Medical Association. (Motion seconded by Dr. Walter C. Bornemeier, Chicago, and carried. The ballot was cast and the President declared Drs. Percy E. Hopkins, Warren W. Furey and Charles H. Phifer elected as delegates to the American Medical Association for a term of two years).

THE PRESIDENT: Nominations are in order for two delegates from downstate.

DR. WILLIAM H. SCHOWENGERDT, Champaign: I would like to nominate Dr. C. Paul White, Kewanee, to succeed himself. (Motion seconded by Dr. Charles P. Blair, Monmouth, and carried. The ballot was cast and the President declared Dr. C. Paul White elected as a delegate to the American Medical Association for a term of two years).

DR. W. W. FULLERTON, Sparta: I would like to nominate Dr. Burtis E. Montgomery, Harrisburg, to succeed himself. (Nomination seconded by Drs. Caesar Portes Chicago and Joseph T. O'Neill, Ottawa).

Nominations from the floor were called for but none were made.

DR. ARTHUR F. GOODYEAR, Decatur: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Burtis E. Montgomery as delegate to the American Medical Association. (Motion seconded by Dr. J. Mather Pfeiffenberger, and carried. The ballot was cast and the President declared Dr. Burtis E. Montgomery, elected as a delegate to the American Medical Association for a term of two years).

THE PRESIDENT: The next item on the agenda is the election of alternate delegates to the American Medical Association, the terms of Drs. James H. Hutton, Karl L. Vehe and G. Henry Mundt, Chicago, Harry Mantz, Alton, and Joseph T. O'Neill, Ottawa, expiring. The Chair recognizes Dr. Norris J. Heckel, Chicago.

DR. HECKEL: I would like to place in nomination as alternate to Dr. Percy C. Hopkins, Dr. Maurice M. Hoeltgen, Cook County. Nomination seconded by Dr. Frank Fowler.

Nominations were called for but none were made.

DR. A. J. BRISLEN, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Maurice M. Hoeltgen. (Motion seconded by Dr. H. Close Hesseltine, Chicago, and carried. The ballot was cast and the President declared Dr. Maurice M. Hoeltgen, elected as an alternate delegate to Dr. Percy E. Hopkins for a term of two years.)

DR. HECKEL: I would like to place in nomination the name of Dr. Leo P. A. Sweeney as alternate to Dr. Warren W. Furey.

Nominations from the floor were called for but none were made.

DR. H. CLOSE HESSELTINE, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Leo P. A. Sweeney. (Motion seconded by Dr. A. M. Vaughn, Chicago, and carried. The ballot was cast and the President declared Dr. Leo P. A. Sweeney, elected as alternate delegate to Dr. Warren W. Furey for a term of two years.)

DR. HECKEL: As alternate to Dr. Charles H. Phifer I would like to nominate Dr. Carl Steinhoff, Chicago. (Nomination seconded by Dr. Caesar Portes).

Nominations from the floor were called for but none were made.

DR. CAESAR PORTES, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Carl Steinhoff. (Motion seconded by Dr. Edwin A. Lukaszewski, Chicago and carried. The ballot was cast and the President declared Dr. Carl Steinhoff elected as alternate to Dr. Charles H. Phifer for a term of two years.)

DR. WARNER NEWCOMB, Jacksonville: I would like to nominate Dr. Harry Mantz, Alton, as alternate to Dr. C. Paul White. (Nomination seconded by Dr. Arthur F. Goodyear).

Nominations from the floor were called for and none were made.

DR. ARTHUR F. GOODYEAR, Decatur: I move that the nominations be closed and Dr. Harry Mantz elected as alternate to Dr. C. Paul White. (Motion seconded by Dr. J. Mather Pfeiffenberger, and carried. The ballot was cast and the President declared Dr. Harry Mantz elected as alternate to Dr. C. Paul White for a term of two years.)

DR. GEORGE E. KIRBY, Bureau County: I would like to place in nomination the name of Dr. Joseph T. O'Neill as alternate to Dr. Burtis E. Montgomery. (Nomination seconded by Dr. Walter E. Kittler).

Nominations from the floor were called for but none were made.

DR. ARTHUR F. GOODYEAR, Decatur: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Joseph T. O'Neill.

(Motion seconded by Dr. George E. Kirby, and carried. The ballot was cast and the President declared Dr. Joseph T. O'Neill elected as alternate to Dr. Burtis E. Montgomery for a term of two years).

THE PRESIDENT: The next item is the election of Standing Committees. The first committee is the Medico-Legal, two members are elected each year for a three year term. The terms of Dr. Edward C. Helfers, Chicago, and Ralph McReynolds, Quincy, expiring. The Chair recognizes Dr. Norris J. Heckel.

DR. HECKEL: I would like to place in nomination the name of Dr. Edward C. Helfers to succeed himself. (Nomination seconded by Dr. Caesar Portes).

Nominations from the floor were called for but none were made.

DR. H. K. SCATLIFF, Chicago: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Edward C. Helfers. (Motion seconded by Dr. J. Ernest Breed, and carried. The ballot was cast and the President declared Dr. Edward C. Helfers elected as a member of the Medico-Legal Committee for a term of three years.)

DR. WARNER H. NEWCOMB, Jacksonville: I would like to nominate Dr. Ralph McReynolds, Quincy, to succeed himself. (Nomination seconded by Dr. William H. Schowengerdt).

Nominations from the floor were called for but none were offered.

DR. NORMAN L. SHEEHE, Rockford: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Ralph McReynolds. (Motion seconded by Dr. Walter E. Kittler, and carried. The ballot was cast and the President declared Dr. Ralph McReynolds elected as a member of the Medico-Legal Committee for a term of three years).

PRESIDENT: Nominations are in order for the Committee on Medical Education and Hospitals, three members elected for a one year term. The terms of Drs. George F. O'Brien. Chicago, Harlan English, Danville, and Karl L. Vehe, Chicago expiring. The Chair recognizes Dr. Norris J. Heckel, representing the Chicago Medical Society.

DR. HECKEL: I would like to place in nomination the names of Drs. George F. O'Brien and Karl L. Vehe to succeed themselves.

Nominations from the floor were called for but none were made.

DR. J. ERNEST BREED, Chicago: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Drs. George F. O'Brien and Karl L. Vehe. (Motion seconded by Dr. H. Close Hesseltine, and carried. The ballot was cast and the President declared Drs. George F. O'Brien and Karl L. Vehe elected as members of the Committee on Medical Education and Hospitals.)

DR. FRED ENDRES, Peoria: I would like to nominate Dr. Ward Eastman Peoria. (Nomination seconded by Dr. Arthur F. Goodyear). No further nominations were offered.

DR. ARTHUR F. GOODYEAR: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Ward Eastman. (Motion seconded by Dr. Fred Endres, and carried. The ballot was cast and the President declared Dr. Ward Eastman, Peoria, elected as a member of the Committee on Medical Education and Hospitals.)

THE PRESIDENT: Nominations are in order for the Committee on Medical Benevolence, one member elected each year for a three year term. The term of Lee O. Frech, Decatur, expiring.

DR. M. D. MURFIN, Decatur: I wish to nominate Dr. Lee O. Frech to succeed himself. (Nomination seconded by Dr. Norman L. Sheehe).

Nominations from the floor were called for but none offered.

DR. J. MATHER PFEIFFENBERGER, Alton: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Frech. (Motion seconded by Dr. E. V. McCarthy, and carried. The ballot was cast and the President declared Dr. Lee O. Frech elected as a member of the Committee on Medical Benevolence for a term of three years.)

THE PRESIDENT: Nominations are in order for the Committee on Medical Testimony, two elected for a four year term. The terms of Adrien Verbrugghen, Chicago, and Everett P. Coleman, Canton, expiring.

DR. NORRIS J. HECKEL: I wish to place in nomination the name of Dr. Leo P. A. Sweeney, Chicago. (Nomination seconded by Dr. Charles H. Phifer, Cook County).

Nominations from the floor were called for but none were made.

DR. J. ERNEST BREED, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Sweeney. (Motion seconded by Dr. H. K. Scatliff, and carried. The ballot was cast and the President declared Dr. Leo P. A. Sweeney elected as a member of the Committee on Medical Testimony).

DR. M. D. MURFIN, Macon Co.: I would like to nominate Dr. H. D. Nesmith, Marion County. (Nomination seconded by Dr. Arthur F. Goodyear).

Nominations from the floor were called for but none were offered.

DR. J. MATHER PFEIFFENBERGER, Alton: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. Nesmith. (Motion seconded by Dr. Arthur F. Goodyear, and carried. The ballot was cast and the President declared Dr. H. D. Nesmith elected as a member of the Committee on Medical Testimony.)

THE PRESIDENT: Nominations are in order for two members of the Grievance Committee, two elected for a three year term, the terms of Drs. Edwin F. Baker, Lewistown, and Harry Mantz, Alton, expiring.

DR. C. D. SWICKARD, Coles-Cumberland Co.: I would like to place in nomination the name of Dr. J. O. Cletcher, Tuscola. (Nomination seconded by Dr. William H. Schowengerdt, Champaign).

DR. J. MATHER PFEIFFENBERGER, Alton: I would like to place in nomination the name of Dr. Harry Mantz, Alton. (Nomination seconded by Dr. Arthur F. Goodyear). No further nominations were offered.

DR. J. MATHER PFEIFFENBERGER: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Drs. J. O. Cletcher and Harry Mantz as members of the Grievance Committee. (Motion seconded by Dr. William H. Schowengerdt, and carried. The ballot was cast and the President declared Drs. J. O. Cletcher and Harry Mantz elected as members of the Grievance Committee).

THE PRESIDENT: Thank you gentlemen. I am sure the Society has done a fine job in electing these gentlemen to the various positions.

The next item of business is fixing the per capita assessment for 1957 dues.

DR. JOSEPH T. O'NEILL, Ottawa: Mr. President, it is the wish of the Council and I so move that the per capita assessment remain the same for the ensuing year, $65.00 including the A. M. A. dues. (Motion seconded by Dr. E. E. Davis, Avon).

DR. EDWARD H. WELD, Rockford: Mr. President and Members of the House of Delegates: I come up here to speak on the compulsory American Medical Education Foundation because for a number of years Winnebago County has violently opposed it, not on the grounds that the doctors do not owe, not on the grounds that they cannot afford it, not on the grounds that there is no need or justice to it, but solely on the grounds that it was compulsory. We were always opposed in this democratic assembly. We thought we

should pay only as other states did. We disliked the compulsory idea. We felt if it was good for Illinois, it was good for Ohio, etc. I come here only as a delegate; I am not instructed by my county. I was amazed at the rather sketchy report that was given by Mr. Hedback of the A. M. A.—practically no new states had been added since last year. I believe one state dropped out. Is this progress? So I went over to the A. M. A. where I have always received cooperation and I learned some surprising facts, some of which you know and some of which you are hazy about. Let us look at the record.

The American Medical Education Foundation raises money for the medical schools from the medical profession, and now from the American public. The first appeal to the American public was made during Medical Education Week in April of this year. You will note that the American Medical Education Foundation has distributed $4,684,000 of the $9,500,000 dispensed to medical schools. The National Manufacturers Association contributed $4,911,000, so a total of over $9,596,000 has been distributed since 1951. When you take the income raised by states for the American Medical Education Foundation, you will note that 45% of the income raised was given in a five year grant by the American Medical Association; approximately 13% came from Illinois; the combined income from California, New York, Pennsylvania, Indiana, and New Jersey represents approximately 23% of the American Medical Education Foundation. The remaining 19% was received from the other 42 states. When you break this down into states as to where this money came from we find that the American Medical Association has contributed approximately $2,100,000, Illinois has contributed $621,000, California, $302,000—California has many more doctors registered than we have and they contributed less than half. New York contributed $205,000, Texas, $196,000, Indiana $158,000, Ohio, $100,000, New Jersey, $76,000. Illinois by compulsory assessment gives $20.00 a year per member. Utah by compulsory assessment gives $20.00 a year per member. For 1955-1956, Nevada gave $10.00, Idaho. $10.00, and California 0, per member: This year $120,000, or 20% of it, was earmarked for California schools. California, gave $102,000 in 1952, nothing in 1953, $100,000 in 1954, and $102,000 in 1955. New York in 1953, 1954, 1955, 1956, gave $205,000; Iowa gives $1.00 per member. There are some states that have a definite assessment. New York gives $10.00 voluntarily per member, Pennsylvania $25.00, District of Columbia, $10.00, Delaware, $10.00. Treasury gifts, that is out of the state treasury, received from the following states in 1955: Massachusetts, $3,000, Oregon, $5.000, Tennessee, $1,000, Virginia, $2.000. Since 1955, the American Medical Education Foundation has distributed over $4,600,000 to medical schools. This includes $2,100,000 from American Medical Association grants. The states where the Illinois Plan has been tried successfully are Pennsylvania, New York, Ohio, Indiana and Texas.

Conclusions: I hate to say this but I like to be honest. I believe that Winnebago County has been wrong. I believe that I personally have been wrong. Secondly, I believe that this money is needed. I believe that the Illinois Plan is definitely and conclusively, and I say this emphatically, the best way to get the money. (Members of the House stand). Third, even though your delegates to the A. M. A. House of Delegates from Illinois have repeatedly advised to promote the American Medical Education Foundation drive in other states according to the Illinois plan, they have failed. Witness Pennsylvania, Ohio, Indiana, and Texas, and why have they failed? Because of the compulsory nature of the matter. Fourth, the seeds have been sewn and other states are asking the A. M. A. to take over and enforce the plan. Once the seeds have been planted, those seeds need to be nourished, and this morning I am doing my best to fertilize those seeds. (Applause). I will go even further. My good friend, Elmer Hess, is in the audience, as are many from medical schools in Chicago. I ask you how many of you have come to your medical schools this past year to see how they are doing their work and how they are spending your money? You have a right to know. You have a right to say how the money will be spent.

I urge you to continue with the Illinois Plan. I urge you to instruct your delegates to the American Medical Association to get on the ball, and urge the American Medical Education Foundation to sell the idea to other states even as you have sold it to me. Now, please, one and all, let us keep medicine free from Federal control. (Applause, and all stood).

THE PRESIDENT: I want to thank you Dr. Weld for your fine expression of your views.

(The motion by Dr. O'Neill that the per capita assessment remain the same as last year, was carried).

THE SECRETARY: I want to give Dr. Weld a little information as to how we are handling our money for the American Medical Education Foundation. We have repeatedly told Dr. Weld that this is not actually compulsory. The dues are set at a figure, the Council allocates $20.00 per member for the American Medical Education Foundation. In previous years we have sent our remittance as the dues came in, at least once a month and sometimes oftener. We have gone to the A. M. A. meetings and have attended the sessions of the House of Delegates each year. The man who is responsible for the operation of the American Medical Education Foundation, primarily at least, is Dr. Louis H. Bauer, past President of the A. M. A. Before the House of Delegates, California comes up and presents a check, and so on down through the states. Dr. Stone and myself at the meeting of the House of Delegates next month at the Palmer House will have a check for approximately $175,000. We are going to send that check a few days before the meeting and they are going to blow it up, so it will be two and half or three feet in size and we are going to present it to the American Medical Education Foundation. We believe and they believe that that will promote similar action among other states. We have been told there are nine states either using the same plan or have accepted the same plan.

DR. ANDERS J. WEIGEN, Cook County: Would it not be a good idea to have a copy of the remarks that Dr. Weld made sent to the American Medical Education Foundation?

THE SECRETARY: This will be published in the minutes. Each of you will receive a supplement in three months or so. If the House so desires we can have this taken real soon and have it printed and distributed.

DR. SWEENEY: I so move. (Motion seconded by Dr. H. Close Hesseltine, and carried).

THE PRESIDENT: The remarks of Dr. Weld, by this motion will be incorporated in the minutes and will be publicized for the benefit of the American Medical Association and the American Medical Education Foundation.

We will now continue with the reports of the Reference Committees and will begin with the unfinished report of Dr. Whiting's Committee on the Reports of Standing Committees.

DR. WHITING: Your Committee in its report previously submitted, inadvertently omitted a comment on the supplementary report of the Committee on Medical Service and Public Relations. We wish to amend this report as follows: We recommend that the supplementary report of the Committee on Medical Service and Public Relations be accepted as information, reiterating the regrets expressed by the Committee and adding our hopes that such conflicts will not reoccur.

(DR. WHITING: I move the adoption of this por-

tion of the report. Motion seconded by Dr. Norris J. Heckel, and carried).

Your Committee reviewed the resolution of the Randolph County Medical Society as published in the Handbook on page 143, and as previously amended by your Reference Committee, which was referred back to the Committee for further action. In consultation with the legal Counsel of the Society the resolution has been rewritten as follows:

WHEREAS, at the present time there are many individuals subject to licensure under the Medical Practice Act practicing their vocation in the State of Illinois without license and,

WHEREAS, convictions of said individuals for practicing without license are extremely difficult to obtain, and

WHEREAS, even if conviction is obtained the punishment is minimal,

THEREFORE BE IT RESOLVED, that the members of the Illinois State Medical Society protest this laxness in law enforcement and recommend to the Legislature of the State of Illinois such modification to the present law as would eliminate the difficulties of prosecution of such cases, and if such conviction is obtained that the punishment be more severe.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. Frank Fowler, and carried).

Considering the problem of medical licensure in relationship to qualifications for practice your Reference Committee considered in great detail all of the aspects related to the resolution presented by the Randolph County Medical Society and published on Page 144 of the Handbook and to the resolution presented in the House of Delegates May 15, 1956 by Madison County. Realizing the many problems associated with this aspect of medical licensure we recommend that these resolutions be not adopted for the following. (1) We interpret these resolutions as an attempt to relate citizenship and qualifications for medical practice which we consider an unrealistic approach. (2) We have been assured by a member of the Examining Board in consultation with the Committee that the examination itself will be a much more comprehensive evaluation of the applicant's medical qualifications.

Taking these matters into consideration and agreeing in principle that citizenship is desirable, we submit the following substitute resolutions:

WHEREAS, it should be the desire of every person who expects to be a permanent resident of these United States, and to derive the benefits thereof to be a citizen of the United States of America,

THEREFORE BE IT RESOLVED, that the members of the House of Delegates of the Illinois State Medical Society notify the Legislature of the State of Illinois that they believe that applicants for registration and licensure under the Medical Practice Act should be citizens of the United States and request an enactment of legislation to accomplish this.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger).

THE PRESIDENT: It has been moved and seconded that this resolution take precedence over the ones published in the Handbook. (Motion carried).

Your Committee received a new resolution yesterday, which dealt with the annual re-registration of practitioners under the jurisdiction of the Medical Practice Act. This resolution has produced a great deal of controversy in committee and the Committee has been approached by sufficient witnesses to indicate that the content deserves considerably more discussion and hearing.

Therefore, we recommend that the following resolution be referred to the Committee on Medical Service and Public Relations for further consideration.

(*For resolution, see, Second Session of House of Delegates.*)

Although the Committee in general was in favor of the content of this resolution, we felt that this action was necessary to effect a proper evaluation of its content, and to inform all of the physicians of the State of Illinois before final action was taken. Therefore, I would like to re-read the resolution in its entirety for informational purposes.

(DR. WHITING: I move the adoption of this portion of the report. Motion seconded by Dr. Harlan English).

DR. HARRY MANTZ, Alton: I do not want to start a big controversy but I do not agree with the idea of the Committee's wanting to shelve this resolution. Dr. Hamilton is for it, and according to Dr. Schnepp's discussion before the Committee, these people want help now. I do not know what purpose it will serve to postpone this resolution for a year. I think the resolution should be put before the House and acted upon at this session.

DR. ANDREW SULLIVAN, Chicago: I am very much aware of the motives that made Dr. Hamilton make these suggestions in the resolution. There is one thing to consider. We are inviting more government interference into the affairs of the practice of medicine. We are asking, in effect that they tax us to pay for their work. I do not consider it a function of the practice of medicine or organized medicine to supply funds for a government function, the money for which should be appropriated by legislative methods. I think this action of the Resolutions Committee should be sustained.

DR. E. S. HAMILTON, Kankakee: Mr. Chairman and Members of the House: That there is a difference of opinion is not at all surprising to me. I think that two years ago I would have talked about the same as Dr. Sullivan did. We must be realistic. There is a serious problem in medical licensure in Illinois. Your medical licensure committee has taken a lot of abuse from the medical profession and from those in allied professions of treating human ills, for the last ten years. I am putting no pressure on you to vote or not to vote. I fully expected that there would be a violent difference of opinion. All I want to tell you is, if you do nothing here you provide the Medical Examining Committee with a handicap. I beg of you when things come up that you do not like do not blame the Medical Examining Committee because of your failure to back up one of the few things we have asked.

DR. C. ELLIOTT BELL, Macon Co.: Having been a native of Pennsylvania for twenty-six years and now practicing in Illinois, I have paid a registration fee of one dollar a year to the sovereign state of Pennsylvania. I have in no way ever felt the weight or pressure of the government of Pennsylvania. I heartily support the proposal which Dr. Hamilton and his Committee make.

DR. H. KENNETH SCATLIFF, Chicago: I appreciate the remarks of Dr. Hamilton. This Committee has done a very valiant service to protect the society and to protect medicine. Nevertheless this is a matter of considerable controversy. It is questionable if the profession will be called upon to pay for this out of their own pockets. I do not believe it will handicap the Committee to postpone this for further study through the pages of the State Journal. I suggest we support the Reference Committee.

DR. FRANK FOWLER, Chicago: I appreciate the problems of the Medical Examining Committee. I do not think anyone in this room has any more respect for my friends on the Medical Examining Board than I have. However, this resolution is not the proper mode of doing what we intended to do. I wish it were. I wish it were able to be carried out. However, when we pay any fees they go directly into the state treasury. The Legislature appropriates money to carry on the function of the Department of Registration and

Education. I hate to take action against the resolution. I think it should be studied. It is just like the gas tax that was put into effect and earmarked for roads. I think the first time this fee would be collected it would be earmarked for the Department and the Department would get it, after that. . . The Department of Registration and Education is not a political plum. They will not get funds unless we put pressure on the State Legislature to appropriate funds and we should do this if we want things carried out.

DR. WILLIAM WALTON, St. Clair County: As a member of this Reference Committee. I might reiterate the reason this is recommended for referral. I do not think this should be acted upon without full and exhaustive consideration. Our communities have accused us of not bringing things back to them. This is your opportunity to go to the crossroads and expound the situation. Like Dr. Bell, I pay to Missouri a fee every two years to maintain my license. In the State of Illinois I pay a license to practice pharmacy before January 30 of each year. This is not new. The state of Missouri has a plan, and if properly studied we might be able to do something in this State Legislature comparable to that, which might take it out of the so-called realm of politics.

DR. A. J. BRISLEN, Chicago: This is the sort of thing that prompted the Committee to come in with its recommendation. This is not middle ground. There are two divergent opinions. It came in with the idea that the matter should be referred and adequately studied. Therefore, I move the previous question.

THE PRESIDENT: All those who want the previous question voted on, say aye; those who do not, say nay. (The motion is carried).

We will now vote on the previous motion, to accept that portion of the report just read. (Motion carried).

DR. WHITING: This report is signed by Drs. A. J. Brislen, Fred A. Tworoger, Peter C. Rumore, William H. Walton, and William Whiting, Chairman. I move the adoption of the report as a whole. (Motion seconded by Dr. Charles P. Eck, Chicago, and carried).

THE PRESIDENT: I want to thank Dr. Whiting and his Committee for all the work they put on their report.

DR. WHITING: I want to take this opportunity to thank all the members of my Committee for the cooperation and enthusiasm they have shown in more than twelve hours of Committee work.

THE PRESIDENT: The next report will be from Reference Committee on Reports of Council Committees "B", Dr. Norman L. Sheehe, Chairman.

*Report of Reference Committee on Reports of Council Committees "B"*

To the Members of the House of Delegates: The report of Council Committee "B" pertaining to the advisory Committee to the United Mine Workers of America is as follows:

Appearing before the Committee were: Dr. Brothers, of St. Louis, Mo., representing the United Mine Workers of America Welfare and Retirement Fund; Dr. Montgomery, Chairman of the Advisory Committee to the U. M. W. A., along with Drs. Fullerton and Mathis of the same Committee; Dr. Frederick W. Slobe of the Committee on Industrial Health of the American Medical Association; Dr. Hoeltgen, Dr. Hamilton, Dr. English, Dr. Endres and Dr. Schowengerdt.

After careful consideration of all of the resolutions of the interested and various county societies, the numerous suggestions brought out in the general discussion before the Committee, it was concluded that the following recommendations be made to the House of Delegates:

1. That the Illinois State Medical Society accept the Pennsylvania plan of the Pennsylvania Medical Society and the U. M. W. A., as shown in the issue of the J. A. M. A. of May 12, 1956, page 164, with modifications so as to comply with the the Illinois Medical Practice Act.
2. That the recommendations from the Joint Committee on Medical Care for Industrial Workers of the Council on Medical Service and the Council on Industrial Health of the American Medical Association be studied and used to the fullest advantage, when it is completed and presented by the Committee at its meeting in June in Chicago.
3. That the Advisory Comittee of the Illinois State Medical Society to the United Mine Workers be enlarged to ten members, one of whom shall be from Chicago; this Committee should act as a consultant and advisor to the United Mine Workers of America through its regional director.
4. That the Advisory Committee to the United Mine Workers operate through a liaison committee consisting of the Grievance Committees of the component county societies involved in the Welfare and Retirement Fund of the United Mine Workers. This should advance the democratic principles and ideals of the medical profession and eliminate the possibility of discrimination, resulting in a more amiable climate between the medical profession and the Mine Workers' Fund.
5. That the present directive issued by the Area Administrator of the U. M. W. on November 1. 1955, be rescinded as it resulted in considerable dissatisfaction among the practicing physicians of the coal mining areas.

(DR. SHEEHE: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. Leo P. A. Sweeney, Cook County and carried).

2. *Report of the Advisory Committee to the Woman's Auxiliary of the Illinois State Medical Society.*

The Chairman of the Advisory Committee, Dr. Leo P. A. Sweeney, appeared before the Committee and gave a short report. We commend this Advisory Committee for its diligent work on the revision of the constitution and by-laws of the Woman's Auxiliary to the Illinois State Medical Society. During the past year the Committee has been in close liaison with the Auxiliary and was always available at their request.

It has been requested by the Advisory Committee that the end of the second sentence of the first paragraph of the Advisory Committee's report read: "That we at all times spoke as representatives of the Council."

(DR. SHEEHE: Mr. President, I move the adoption of this portion of the report. Motion seconded by Dr. H. Close Hesseltine, Cook County, and carried).

3. *Report of the Advisory Committee to Selective Service.*

This Committee has been busy, reviewing the cases of all physicians who have not entered on Active Duty. Also talked to June graduates in four medical schools as to their military liability. The Advisory Committee has also assisted in reviewing the resident staffs of all hospitals and universities to make certain that all physicians under 45 years of age are registered with Selective Service. The Committee recommends that the County Societies give all necessary help to the Advisory Committee to Selective Service in clearing up the foreign internes and residents who evade the doctor draft. The Advisory Committee to Selective Service has found it difficult to cope with the problem of the foreign born and graduates of foreign medical schools, many of whom have taken refuge as residents and internes in our various institutions. Many of them have failed to comply with the laws of Selective Service and thus evade induction, whereas the American graduates carry the brunt of Selective Service at this time.

Our Committee suggests that the Council review the

possibilities of instituting an annual registration law which would give valuable information to Selective Service in combating this problem.

(DR. SHEEHE: Mr. President: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, Madison County, and carried).

4. *Committee on Blood Banks.*

The report is recommended for adoption with the exception, that the $6,000.00 requested by the Clearing House for adjustment of their financial operations not be granted, as we are informed that they have already obtained this money elsewhere; that the previous loan made by the Illinois State Medical Society to the Clearing House, amounting to $6,000.00 be liquidated by the borrower as rapidly as possible within their financial limits.

(DR. SHEEHE: Mr. President: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

5. *Committee on Cancer Control.*

Dr. Caesar Portes, a member of the Committee on Cancer Control, appeared before the Reference Committee and stated that the Memphis group in its use of vaginal smears for cancer detection has found the method very revealing, and our Committee endorses its judicious use throughout the State of Illinois. It also endorses a continuation of the lay education program on cancer. The Committee suggests that a Papanicolaou Reviewing Center be established downstate in connection with the State Laboratories at Springfield.

The refresher courses have been continued. The one held in February, 1956 in Chicago for three days was well attended by both downstate and Chicago doctors, who were taken to the various medical schools in Chicago.

A sponsored program for the dental profession was held at the University of Illinois College of Dentistry. It was so well attended that many applicants had to be refused because of lack of space.

The Committee recommends the adoption of the Cancer Control Report as a whole and commends them for the diligent work on this project.

(DR. SHEEHE: Mr. President: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, and carried).

6. *Committee on Cardiovascular Disease.*

The report of this Committee was carefully reviewed. The Reference Committee commends the Committee for its work in the past year and recommends the adoption of the report as a whole.

(DR. SHEEHE: Mr. President; I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, and carried).

7. *President, Woman's Auxiliary.*

It is difficult to evaluate in a short space the work accomplished by the Woman's Auxiliary to the Illinois State Medical Society during this past year. Suffice it to say, that it was outstanding under the splendid leadership of the President, Mrs. Warren W. Young, of Chicago.

With a total membership of 2,663, an increase over the previous year, all programs have been executed in a noteworthy manner.

With a late start in furthering the cause of the American Medical Education Fund, a commendable sum was collected, with over $2000.00 of the entire amount secured in the Third District.

The Woman's Auxiliary again was generous in presenting the Benevolence Fund with a most acceptable check that totaled nearly $4000.00.

We were particularly pleased with the fine cooperation on Legislative matters. The many letters and telegrams that were sent out supporting our aims were effective and appreciative.

In Nurse Recruitment $5,070.00 has been contributed by the County Auxiliaries for nurse scholarships or Loan Funds. Thirty-three Future Nurses Clubs are being sponsored by these county groups, also.

In the matter of Public Relations the Auxiliary has done a magnificent job in assisting local organizations, such as the American Red Cross, Cancer and Heart Funds, etc., in carrying out their programs. They have won the praise of such local groups and we appreciate the splendid cooperation which indirectly reflects on our medical societies.

The State President, Mrs. Young, has recommended with reference to the resolutions set out as Items 6, 7 and 8 on Pages 92 and 93 of the Illinois Medical Journal for July, 1955, that *"this matter be left to the Woman's Auxiliary to the Illinois State Medical Society for disposition by its members at such time and under such circumstances as they deem proper."* Your Committee recommends that this recommendation be accepted with the proviso that the new constitution and by-laws will be acted upon at the next annual convention, in view of the fact that the Auxiliary is in the process of revising its constitution and by-laws during the coming year with the purpose in mind of setting up a more equitable representation in its component parts.

The Committee whose task it will be to accomplish this work will be elected at their 28th annual meeting. The members of the Committee will be composed of three members from downstate and two members from the Cook County area. It seems fair to assume that the Woman's Auxiliary will work out a suitable and acceptable answer to the problem at hand.

Your Committee suggests that the Advisory Committee to the Woman's Auxiliary avail themselves of any assistance from the Constitution and By-Laws Committee that is deemed necessary.

(DR. SHEEHE: Mr. President: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

DR. SHEEHE: At this time I want to thank the Staff who gave so much of their time to my Committee. I want to thank our President of the State Society for offering me a chance to work as Chairman of a Reference Committee. This report is signed by Drs. Paul Baur, H. E. Fehrenbacher, L. S. Tichy and Norman L. Sheehe, Chairman. Dr. Warren C. Blim was not present at any session. I move the adoption of the report as a whole. (Motion seconded by Dr. J. M. Pfeiffenberger, and carried).

The next report of the Reference Committee on Reports of Council Committees "C", Dr. John R. Wolff, Chairman.

*Report of Reference Committee on Report of Council Committees "C"*

*Constitution and By-Laws Committee*: We concur in the proposed changes as presented in the Handbook. Item 1. Article V, Section (c) to read: "Past presidents shall be ex-officio members without the right to vote".

Item 2. This concerns the tenure of office for members of the Committee on Medical Service and Public Relations.

Item 3. This concerns the functions of the Grievance Committee.

This Committee is to be thanked for its fine efforts. The constitution and by-laws of an organization must be a living document. One that maintains tradition, and safeguards principle yet keeps pace with an ever changing world. Our Constitution is such a model due to the wisdom and knowledge of the Chairman of the Constitution and By-Laws Committee.

Item 4. Concerns emeritus members by adding to Article IV, Section 3, "Credit for membership in other American Medical Association constituent societies

shall be accorded transferees, provided they have been members of this Society for at least five years."

(DR. WOLFF: I move the adoption of this portion of the report).

THE PRESIDENT: We are voting on changes in the constitution, therefore each item will be voted on individually.

(DR. WOLFF: I move the adoption of item 1, the proposed amendment to Article V, Section (c) to read: "Past presidents shall be ex-officio members without right to vote". (Motion seconded by Dr. E. S. Hamilton, and carried).

DR. WOLFF: I move the adoption of item 2, concerning the tenure of office for members of the Committee on Medical Service and Public Relations. (Motion seconded by Dr. Anders J. Weigen, and carried).

I move the adoption of item 3, concerning the functions of the Grievance Committee. (Motion seconded by Dr. C. P. Blair, Monmouth, and carried).

I move the adoption of item 4, the supplementary report given to the Committee concerning the addition of Article IV, Section 3. (Motion seconded by Dr. Frank Fowler, and carried).

I move the adoption of the report of the Constitution and By-Laws Committee. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

*Crippled Children's Clinic Committee*: This group reports the work of these clinics throughout the State of Illinois. It is agreed that they are doing a remarkable job. This demonstrates how an alert medical society through the activities of its individual members can successfully cooperate with the federal government, the state government, the Department of Public Health, the State University, and lay organizations without endangering the freedom of medical practice.

(DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, Chicago, and carried).

*Committee To Study the Coroner's Act*: This Committee has done a tremendous job. For over 25 years we in the Illinois State Medical Society have attempted to improve the functions of the office of the coroner. Finally we have some success in the passage and adoption of H. B. 248. It is regrettable and not quite understandable that our great Governor decided to veto H. B. 247. We must work for a successful passage in the next session. The Committee must keep up its activities and we at the local level must help to the best of our ability.

(DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

*Committee on Diabetes*: This Committee did not meet but has presented a report on diabetic detection activities. The Committee is alert to the increasing needs for diabetic services. It is assumed that the scope of this Committee's activities will be increased in the ensuing year.

DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

*Educational Committee*: This activity of our Society is well known. This group is doing a splendid piece of work. Your Reference Committee had considerable discussion on the subject of lay medical education. We realize the many problems that are involved. We also realize the great demand that exists for knowledge on medical subjects. This Committee is to be thanked for proceeding in such an excellent manner.

(DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

*Ethical Relations Committee*: No cases. No meetings. Three cheers!

(DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, and carried).

*Fifty Year Club Committee*: A great organization. Your Reference Committee hopes that all its members will one day be able to join this fine club, and that Dr. Andy Hall will be the perpetual chairman.

(DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

*Interprofessional Relations Committee*: Your Reference Committee agrees with the Council of the Illinois State Medical Society that the Interprofessional Council is a worthwhile organization. This organization helps us in the field of public relations. It is much better to sit down at a table and discuss mutual problems in a friendly fashion than to remain aloof and isolated. Dr. G. Henry Mundt expressed the views of many of the ophthalmologists of the state. They feel that our meeting with the optometrists not only opens the door for that group but expresses an approval of their activities. As you know, the Judicial Council of the A. M. A. has agreed that since this organzation is in essence a political body this Interprofessional Council can proceed without fear of violating ethical principles. The Reference Committee agrees with this viewpoint and hopes that the Interprofessional Council will continue its activities.

(DR. WOLFF: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

DR. G. HENRY MUNDT, Cook County: Yesterday I attended a Referenec Committee meeting considering the Interprofessional Council; I was very courteously listened to and I appreciate that to the full. Last year I spoke to the second session of the House of Delegates of the Illinois State Medical Society on what I thought was an error on the part of the Illinois State Medical Society.

I belong to a segment of organized medicine which has many things to recommend it, may I call your attention that Ophthalmology was the first group in medicine to establish standards of competence in any specialty? Some of you may think that specialty Boards have been of no value; however, I think that it is the consensus that they have done a splendid job. The second Board established was the Board on Otolaryngology. The Illinois State Medical Society has a Section on Eye, Ear, Nose and Throat. Is it fair that this legislative group slap down a section of our own Society? I think it is not.

At the annual meeting of the American Medical Association (less than thirty days after our meeting last year) the Section on Ophthalmology of the American Medical Association recommended the severance of all connection between Ophthalmology and Optometry, parenthetically may I say that the Interprofessional Council of Ophthalmology and Optometry which was a clearing house on visual examinations (in schools, industries, etc.) was discontinued.

The House of Delegates of the American Medical Association sanctioned, I think without a dissenting vote, the action of the Section on Ophthalmology.

You say to me that there was a ruling of the Judicial Council on April 2, 1956, which sanctioned the Illinois Interprofessionl Council. When one reads that opinion one will find that the second paragraph starts as follows: "The Judicial Council, after careful consideration of the *statements made in your letter,* unanimously agreed that in its opinion the Illinois Interprofessional Council is a *political or legislative body* as distinguished from a purely professional body and that therefore the associations or relationships which obtain among the several members on the Interprofessional Council are not professional associations or consultations as contemplated in Chapter II, Section I of

the Principles of Medical Ethics."

Last evening a group discussed that letter; while I indict no one for writing that letter every individual in this room knows that letters are usually written with the opinion of the writer showing definitely. The last paragraph of the report of the Judicial Council is as follows: *"It is the concensus of the members of the Judicial Council that the participation of the Illinois State Medical Society as a member of the Illinois Interprofessional Council is not contrary to the spirit or intent of the Principles of Medical Ethics."*

I am not talking to you about whether this is contrary to the spirit or intent of Medical Ethics, I am asking you about whether we are actually protecting the people's health and whether we are being fair to a segment of medicine (Ophthalmology) which has definitely expressed itself on this subject.

I was involved in sanctioning a new optometry bill two or three years ago. I was acting at the request of the Illinois Society for the Prevention of Blindness.

Therefore, Mr. President, I move that approval of this section including optometrists in the Interprofessional Council, may be eliminated from the report.

DR. MAURICE M. HOELTGEN: Since I was a participant in this resolution last year from the Chicago Medical Society, I would like to second Dr. Mundt's motion.

THE PRESIDENT: The motion that Dr. Mundt proposes is an amendment to the motion to adopt that portion of the Committee's report.

DR. WALTER C. BORNEMEIER, Chicago: I would like to have the motion re-read.

(Motion re-read)

DR. E. S. HAMILTON, Kankakee: May we have the original motion.

DR. WOLFF: The original motion was merely to adopt the portion of this report, and this Committee was to continue its activities.

THE PRESIDENT: We are voting on the amendment proposed by Dr. Mundt and seconded by Dr. Hoeltgen. (The amendment was lost).

DR. E. S. HAMILTON, Kankakee: Let us have a standing vote.

THE PRESIDENT: In order to clarify the vote a standing vote is called for. The vote was taken).

Gentlemen, the poll by standing vote shows the amendment is lost. We will now vote on the original motion which is to approve the portion of the report just read by Dr. Wolff. Is there any discussion? (Motion carried).

(Dr. Wolff continues with the report)

DR. WOLFF:

The report is signed by Drs. Carl F. Steinhoff, Clarence A. Norberg, N. A. Thompson, Jack Gibbs, George E. Kirby, Warren W. Young, and John R. Wolff, Chairman. I move the adoption of the report as a whole. (Motion seconded by Dr. Charles P. Eck, and carried).

THE PRESIDENT: The next report is that of the Reference Committee on Reports of Council Committees, "D", Dr. J. O. Cletcher, Chairman.

*Report of the Reference Committee on Reports of Council Committees "D"*

1. *Committee on Industrial Health*: First, we probably recognize that the subject of industrial health is one of our most controversial problems. Your Committee has studied the report of the Committee on Industrial Health and can only say complimentary things about their work. In general, we think they have covered the subject very well and we appreciate it. From Mr. Oblinger we offer the following comments:

"The Committee considered the problems of Workmen's Compensation and wishes to especially commend the Committee on Industrial Health for its fine work in this field. It is to be hoped that the Committee will be able to follow through on its program to get a new law enacted in Illinois which will solve the problems of free choice of physician, rehabilitation instead of cash payments, and to correct certain defects in the present system of administration."

We especially recommend the reading and study of the A. M. A. report( "Medical Relations in Workmen's Compensation", as of December 1955, especially the Statutory Provision and Comment D on disabled employees in selecting a physician (on page 4).

(DR. CLETCHER: Mr. President, I move the adoption of this portion of our report. Motion seconded by Dr. Charles P. Eck, Cook County, and carried).

2. *Liaison Committee to American Legion (Illinois)*: Our Committee also considers this a very controversial problem. We consider their work very commendable and can hardly make a material addition to their report. Of course, we oppose treatment for non-service disability, but this often needs fluctuation. We would suggest that the Post Graduate Committee arrange for instructive work in our future postgraduate meetings.

(DR. CLETCHER: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

3. *Liaison Committee on Medical Education*: We find that this Committee's report is very short, even though they have had some activity. We feel that they are wide awake on the subject, and if any material of interest comes along, they will report on it.

(DR. CLETCHER: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

4. *Committee on Maternal Welfare*: Your Committee finds this a very interesting and timely report. The report covers a great deal of work and we can only suggest that the Committee's work be broadened. We would suggest that the programs of the Postgraduate Assemblies in the Councilor districts give some thought to the Maternal Welfare Committee's work. The downstate districts would be particularly interested in the findings of improvement in maternal welfare.

(DR. CLETCHER: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

5. *Committee on Medical Economics*: We feel that this Committee is doing a good job in the field of medical economics. We can only suggest that they broaden the field on subjects such as the medical cost and the hospital cost with the trend of the times.

We feel that the stimulation in the study of medical economics should be carried to the doctors in general.

(DR. CLETCHER: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

6. *Committee on Medical History*: This Committee's report is very short and we take it that it is inactive at the present time. We understand from one of the Councilors that the sale of the book is very low and should be stimulated especially from the economical standpoint of the State Society. I also understand that there is some deficit outstanding.

(DR. CLETCHER: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, and carried).

7. *Committee on Mental Health*: This Committee has been on its proverbial toes and we find its work most satisfactory.

Mental health is becoming more of an entity and public concern is growing. Dr. Slobe sat in our meeting and announced the following suggestions:

The Committee is cognizant of the steady improvement being effected by the Illinois Department of Public Welfare. However, it is cognizant of the critical shortage in personnel that has been apparent—psychiatrists, other physicians, nurses and attendants. To correct that, one important factor is the need for in-

creased budgetary appropriations to correct this situation. This will allow salary increases and other inducements as well as funds for needed construction and maintenance. Your chairman discussed this point with Dr. Otto Bettag, Director of the Illinois Department of Public Welfare, who pointed out that merely increasing the appropriations will not overcome the national bottleneck in recruiting professional staffs. A realistic salary scale accompanied with sufficient funds will be of material assistance. The present state salaries are in essence the 1951 levels. Dr. Bettag also reports that there has been an addition of 1111 employees in the past few years primarily in the area of patient care and treatment. Twenty-five physicians will be in resident training in psychiatry this summer and 50 next summer. We have had a net gain of approximately 35 physicians since July 1955. At present over 100 young women and men are being financed through nurses training in the various 72 approved nursing schools in Illinois. By September, 1956 we anticipate our nursing scholarship grant will include over 200. These students will later be employed in the Illinois Department of Public Welfare at regular salary on the basis of one year for each year of scholarship training.

The Chairman of your Reference Committee takes this opportunity to thank the Committee personnel for its cooperation and timely support in making this report.

(DR. CLETCHER: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, and carried).

DR. CLETCHER: This report is signed by Drs. Carl E. Sibilsky, William A. Moore, W. C. Bornemeier, K. L. Vehe, J. E. Bohan, and J. O. Cletcher, Chairman. I move the adoption of the report as a whole. (Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

THE PRESIDENT: Thank you Dr. Cletcher. The next report will be from the Reference Committee on Reports of Council Committees "E", Dr. James H. Hutton, Chairman.

*Report of Reference Committee on Reports of Council Committees "E"*

1. *The Committee on Military Affairs and Emergency Medical Service*: This Committee has had no meeting during the past year. Further progress awaits the report of the national survival study. The Committee is to be commended for attention to this study.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, and carried).

2. *The Necrologist*: The Reference Committee regrets the length of this report, and hopes that it will be shorter next year. Dr. Weld is to be commended for his attention to this sad subject. The Committee moves that the House of Delegates stand a minute in silent tribute to the memory of our deceased.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, and carried. The House stood for one minute).

3. *Committee on Nursing and the Joint Commission on Care of the Patient*: The reports on these two committees were considered at the same time. They were discussed by Dr. Hoeltgen and other members of the Committee and by several other members of the Society. The major portion of two hours was spent in consideration of these reports. The following points were established or suggested: (A) The population is definitely increasing while the number of nurses and schools of nursing are decreasing. It was the Reference Committee's impression that the responsibility for this decrease is due to certain rules and regulations promulgated by the National League for Nursing. (B) It appears to this Committee that the care of the patient has had little consideration in the thinking of the National League for Nursing. (C) It also appears to us that the National League for Nursing has been a major factor in bringing about the present unsatisfactory situation regarding the nursing problem in Illinois.

The Chairman and other members of the Nursing Committee suggested that the Illinois State Medical Society do all within its power to aid in the re-establishment of a School of Nursing in the LaSalle-Ottawa-Peru area.

We wish to commend the members of these committees for the quality and quantity of work they did and for their presentation before the Reference Committee.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

One resolution was given to the Committee (See Second Session of the House. The resolution was adopted at that Session.)

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, and carried).

4. *Postgraduate Education Committee*: The widespread interest in this subject was shown by the large number of discussants who appeared before the Reference Committee. There was general complaint at the small attendance at many Postgraduate Conferences. Suggestions were made that liaison with the Illinois Academy of General Practice be considered in the planning of these meetings. There was general complaint that there are too many medical meetings. One speaker thought it might be necessary to reconsider the entire plan of Postgraduate Education. We highly commend the work of this Committee and the only suggestions are relative to increasing attendance at its conferences.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, and carried).

5. *Committee on Rural Medical Service*: We view the work of this Committee as one of the outstanding accomplishments of this Society. Discussion before the Reference Committee raised the question as to the feasability of a similar service being provided for blighted areas in our cities.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. E. E. Davis, and carried).

6. *Committee on Nutrition*: This highly important subject is probably insufficiently appreciated by most of us. The Committee is to be commended for the progress they have evolved, for the pleasant contacts they have established with lay organizations as well as the profession, and for bringing the entire matter more forcefully to the attention of the public and profession.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

7. *Committee on Scientific Work*: This Reference Committee feels that the planning and conduct of this present meeting is ample evidence of the efficiency with which this Committee works. This Reference Committee has no further recommendations.

(DR. HUTTON: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

DR. HUTTON: This report is signed by Drs. L. J. Jurek, Robert R. Mustell, J. C. Ellis, Tom Kirkwood, H. D. Nesmith, and James H. Hutton, Chairman. I move the adoption of the entire report. (Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

THE PRESIDENT: The motion to accept the re-

port is carried with the thanks of the House and Chair to Dr. Hutton and his Committee.

DR. HUTTON: The Chairman wishes to thank the Committee and the people who appeared before the Committee as well as the members of Dr. Camp's staff.

THE PRESIDENT: The next report is from the Reference Committee on Miscellaneous Business, Dr. George B. Callahan, Chairman.

*Report of Reference Committee on Miscellaneous Business*

With the entire Committee and one alternate, Dr. A. J. Linowiecki, present, the four Committee reports assigned were reviewed and discussed by all attending.

*Scientific Service Committee*: Dr. Limarzi presenting. The report was approved as printed in the Handbook for Delegates and emphasized in the following manner: Paragraph 5, page 132—attempt to prevent such confusion. Paragraph 2, page 131—that part asking for combined meetings in societies with small membership. Paragraph 1, page 133—in regard to "request assistance on short notice basis" with the idea that requests be made six to eight weeks previous to meetings with a minimum absolute of four weeks. Paragraph 3, page 133—to add that new list of speakers be filed in the Chicago and Monmouth offices of the State Society and copies be mailed to each county program chairman and secretary.

The Reference Committee on Miscellaneous Business wishes to commend the members of the Scientific Service Committee for their work during the past year.

(DR. CALLAHAN: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

*Tuberculosis Control Committee*: Dr. Turner presenting. Page 135, last paragraph—emphasis upon the Committee's three recommendations to the House of Delegates and recommendations 1 and 2; we add a request for a letter from the Secretary of the State Society to all component county societies, with all recommendations as passed by them.

The Reference Committee on Miscellaneous Business wishes to commend the members of the Tuberculosis Control Committee for their work during the past year.

(DR. CALLAHAN: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

*Voluntary Prepayment Plans for Medical and Surgical Care*

Dr. Furey presenting. Report approved as printed.

The Reference Committee on Miscellaneous Business wishes to commend the members of the Committee on Voluntary Prepayment Plans for Medical and Surgical Care for their work during the past year.

(DR. CALLAHAN: I move the adoption of this portion of the report. Motion seconded by Dr. Charles P. Eck, and carried).

*Polio Vaccine Committee*: Dr. Reichert presenting. Report approved as printed with these additional requests: The copies of more recent and more detailed report presented to the State Medical Society Council on April 22 be in the hands of the delegates before the adjournment of this meeting and appear in the State Journal at the earliest possible date.

The Reference Committee on Miscellaneous Business wishes to commend the members of the Polio Vaccine Committee for their work during the past year.

(DR. CALLAHAN: I move the adoption of this portion of the report. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

The Chairman wishes to thank and commend the members of this Reference Committee for attendance of full membership and one alternate delegate, and the people who appeared before the Committee. The report is signed by Drs. R. F. Millet, Harry E. Mantz, George Turner, Frank F. Maple, and George B. Callahan, Chairman.

(DR. CALLAHAN: I move the adoption of the report as a whole. Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

THE PRESIDENT: I wish to thank all members of the Reference Committees, those who appeared before the various committees and also the office staff for getting the material out on time.

There is no unfinished business, so we will take up new business. The Chair recognizes Dr. J. Ernest Breed of Chicago.

DR. BREED: I have been informed that the type for the History of Medical Practice in Illinois is about to be broken down. It costs money to have this type made, and having paid for 1000 and having sold only 500. Inasmuch as the medical profession needs good public relations, to me this book gives an opportunity to reach a large number of people, particularly if it were put in high school libraries. I think it would be a good idea to place a copy of this book in every high school library of the state. I move that a plan to distribute a copy of this Medical History to each high school library be referred to the Council for consideration. (Motion seconded by Dr. E. A Lukaszewski, Chicago).

DR. H. KENNETH SCATLIFF: This suggestion was advanced in the early days of the Committee but there were no means of implementing it. Since there are some copies left and the type is to be destroyed, I think this would be a good idea. (Motion carried).

THE PRESIDENT: This goes to the Council.

DR. JAMES H. HUTTON: I speak for the Chairman of the Committee in thanking Dr. Breed and Dr. Scatliff for bringing this before the House. I wonder if this type has already been destroyed.

THE SECRETARY: Not yet.

DR. HUTTON: I move that this House ask the Council to hold this type without destruction until we decide what can be done. We would like to distribute the books to high school libraries and perhaps to other libraries. (Motion seconded by Dr. G. Henry Mundt, and carried).

THE PRESIDENT: We are honored again, gentlemen, by having with us the President of the American Medical Association. It would please the Chair if Dr. Hess would join us on the rostrum and if he has any remarks to make, we shall be pleased to hear them. (The House stands)

DR. ELMER HESS: I have not a thing to say except to thank you for the efficient way in which you work.

THE PRESIDENT: I said the other day that we were honored by having the President of the American Medical Association with us. According to Dr. Camp's information, this is the first time we have had a President of the A. M. A. with us throughout the annual meeting.

THE SECRETARY: I have a little matter. I believe you will all agree that this House has been cared for very satisfactorily this year. The President like the President of the A. M. A. has not been home very much this year. I believe you will be willing to give the President a standing vote of thanks for his work this year. (Standing vote of thanks)

THE PRESIDENT: Thank you all.

THE SECRETARY: I would like permission to send the usual thank-you letters to those who helped to make the meeting a success, such as the press, the hotel. etc.

DR. H. KENNETH SCATLIFF: I so move. (Motion seconded by Dr. J. Mather Pfeiffenberger, and carried).

THE SECRETARY: Next year we will have the same type of seating arrangement for the House and the same type of program and Handbook. It is a lot of work but it pays good dividends.

THE PRESIDENT: We now come to the final item on the agenda the induction of the President-Elect into the office of President.

Gentlemen of the House of Delegates: One axiom from my father has stood me in good stead over the years. He told me early, "Take your job seriously but don't take yourself seriously in your job." My off-side remarks to this House have shown, I hope, that I have tried to follow that.

I shall get in a plug for Illinois College at Jacksonville in this next comment. Dr. Vaughn in his complimentary remarks the other evening referred to my being Secretary of the Board of Trustees at that College. Reverend Fred Hoskins who gave the invocation at our banquet is the present Chairman of that Board. Dr. George Edwin Baxter, an eminent pediatrician here in Chicago up to his retirement, is a former Chairman. He made a statement about my minutes of the Board meetings, that he never knew what he would find in them. I rejoined in the next set of minutes that I never did either. Younger Illinois College Alumni, Jacksonville born and bred, Dr. Dobyns and Dr. Rammelkamp, highlighted this association for me at this meeting. I rarely used during World War II, R. H. I. P., "Rank hath its privileges". The instances mentioned above are the only occasions during this past year where I have used these prerogatives.

As far as this meeting, there was no need for me as regards the program. Dr. Annan and his Committee on Scientific Work have done an outstanding job. Out of state speakers out of state guests, the President of the Indiana State Medical Society. Dr. Kennedy, and others have asked me about this. I tell them, "I live in Illinois." Our whole Society, this House and your President are appreciative of the scientific program. Perhaps next year I can get to hear a paper or two!

I told Dr. Stone yesterday that if he had half as much fun presiding at the meetings of this House as I have had, he would be happy indeed. This has been a culmination of a very fine year for me, thanks to all of you and to all the members of the Society.

My family and I are grateful indeed to individual members and their families, to component societies, to the Council, to the members of this House, to the Woman's Auxiliary and to the office group for the many personal, professional and administrative kindnesses shown me.

I referred in my report to this House to my waistline. My successor can carry that sort of thing better than I. I wish him well on what Dr. Frank Fowler calls "the banquet circuit." He can also carry well the duties and the responsibilities of the Presidency of the Illinois State Medical Society. So it is with personal pleasure and with thanks for all his help during this past year that I turn this gavel over to Dr. F. Lee Stone, our president, your friend and mine. Your best wishes and mine go with him and Mrs. Stone throughout the year and for the years to come. Dr. Stone.

DR. F. LEE STONE: There are many honors that can befall a man, but none so great as when his colleagues place him at the head of their organization. I am humbly mindful of the privilege and of the serious obligations which the presidency of the Illinois State Medical Society imposes.

During the past year, Garm Norbury's inspirational leadership has made my indoctrination as president-elect pleasant and memorable. Much of what I shall do during the coming year will be in support of the ideas which he has sponsored, with the hope that perhaps I, too, may contribute something to the aims of our profession in general and the aspirations of the Illinois State Medical Society in particular.

Our state legislature will assemble for its regular biennial session during the year ahead. As in the past, there will be a number of measures with medical implications presented before this body. We will have to be alert to those which threaten the quality of medical care that is being provided for our citizens, and strong in support of those that will make the practice of medicine in Illinois second to none.

Despite impressive gains in the prevention of traffic accidents, Illinois, as other parts of the nation, is still confronted with a dreadful toll of deaths and injuries on its streets and highways. We physicians can do much in pressing for even more rigid enforcement of our state traffic regulations, since the careless and arrogant driver recognizes only the authority of law. He has no regard for human suffering except only when another careless or arrogant driver strikes down him or some member of his family. If our present traffic laws are inadequate to cope with the speed-crazy and indifferent, then we need new and stronger laws.

The toll of accidents in our homes and factories also presents a problem of undiminished importance to the medical profession. When we physicians think in terms of preventive medicine, we should also think in terms of accident prevention, and I believe that in the future more of us will spend more of our time doing just that.

For every accident that is avoided, there is freed that much of physician time and hospital service for the care of the sick, and for important research in the prevention and treatment of disease.

The profession has demonstrated in the past that it can be effective in the prevention of accidents. Thousands of lives have been saved in plants, homes, offices and on the highways through the efforts of doctors. For a number of years physicians pressed for the installation of safety belts in automobiles. Car manufacturers have now made such belts available and traffic accident reports already indicate the wisdom of this move.

Although I have placed much emphasis on the prevention of accidents in the home, factory and on the highway, it is not my intention to discount the many other medical problems which confront us.

Although great gains have been made in the field of preventive medicine particularly during the past 25 years, we still have tremendous foes to overcome—heart disease, cancer, mental illness and a number of other destructive diseases.

During his presidency, Dr. Norbury did much to stimulate fresh ideas pertaining to the mental health problem in Illinois. In the year ahead we must continue to pursue vigorously different approaches towards the improvement of the health and welfare of our fellow citizens.

We must also continue to press for passage of a law which would establish a coroner's system that would bring acclaim to Illinois instead of mockery. We have a serious nursing situation that must be resolved. Our excellent school health program and our splendid liaison with the Health Department must be maintained. Our work in the field of industrial health has been outstanding and should be encouraged even more.

The Illinois State Medical Society ranks as one of the largest medical associations in the nation. We may never, because of the course of geographic distribution, rank as Number One in membership, but by working together as a solid unit we can rate as the *greatest* state medical organization.

It is only with your help that I can succeed as your president; without it I can accomplish nothing. Thank you again for your expression of confidence in me.

DR. JOSEPH T. O'NEILL, Ottawa: As Chairman of the Council we have been signally honored by the presence of Dr. Elmer Hess at our annual meeting. I should like to move that it be the expression of this body that the Secretary send Dr. Hess a letter of appreciation for his presence at our annual meeting in 1956. (Motion seconded by the President and carried).

THE PRESIDENT: If there is no other business, I will entertain a motion for adjournment.

DR. E. S. HAMILTON, Kankakee: I move that we adjourn sine die. (Motion seconded by Dr. Norman L. Sheehe, Rockford, and carried).

The House adjourned sine die at 11:50 A. M.

46215

Illinois medical journal.
AUTHOR

v.109-110, 1956
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